# MEDICARE POST-ACUTE CARE DELIVERY AND OPTIONS TO IMPROVE IT

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

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# MEDICARE POST-ACUTE CARE DELIVERY AND OPTIONS TO IMPROVE IT

**THURSDAY, APRIL 16, 2015**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
*Washington, DC.*

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton (ex officio), Green, Engel, Capps, Butterfield, Castor, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Also Present: Representative McKinley

Staff Present: Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Robert Horne, Professional Staff Member, Health; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment & Economy; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; John Stone, Counsel, Health; Josh Trent, Professional Staff Member, Health; Traci Vitek, HHS Detailee, Health; Ziky Ababiya, Minority Policy Analyst; Jen Berenholz, Minority Chief Clerk; Christine Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; and Arielle Woronoff, Minority Health Counsel.

## OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Over the past several years, this committee has focused on understanding and responding to the need to modernize Medicare's financing and payment structures. Today's hearing will give members and stakeholders an opportunity to examine the current state of post-acute care, PAC, for Medicare beneficiaries and discuss ways it can be improved.

Post-acute care is care that is provided to individuals who need additional help recuperating from an acute illness or serious medical procedure usually after discharge from hospital care. Post-acute care providers such as skilled nursing facilities, SNFs, inpatient rehabilitation facilities, IRFs, long-term care hospitals, home

health agencies, and hospices are reimbursed by Medicare with different payment systems, which were originally designed to focus on a phase of a patient's illness in a specific site of service. As a result, payments across post-acute care settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar.

According to the Medicare Payment Advisory Commission, MedPAC, Medicare's payments to PAC providers totaled $59 billion in the year 2013. For patients who are hospitalized for exacerbations of chronic conditions, such as congestive heart failure, Medicare spends nearly as much on post-acute care and readmissions in the first 30 days after a patient is discharged as it does for the initial hospital admission. Medicare payments for post-acute care have grown faster than most other categories of spending. For example, total Medicare spending for patients hospitalized with myocardial infarction, congestive heart failure, or hip fracture grew by 1.5 to 2 percent each year between 1994 and 2009, while spending on post-acute care for those patients grew by 4 ½ to 8 ½ percent per year.

There are many opportunities for the Medicare program to save taxpayer dollars and improve seniors' quality of care through better management of post-acute care. One way is to make sure patients are treated in the most cost effective clinically appropriate setting. The current model has significant reimbursement disparities for treating the same condition. For example, for patients hospitalized with congestive heart failure in 2008, Medicare paid about $2,500 in the 30 days after discharge for each patient who received home health care as compared with $10,700 for those admitted to a SNF and $15,000 for those cared for in a rehabilitation hospital.

Our colleague, Representative Dave McKinley, has had a long interest in this subject and has sponsored legislation, along with Representatives Tom Price, John McNerney and Anna Eshoo to provide bundled payments for post-acute care services under Medicare. His bill is H.R. 1458, the quote, "Bundling and Coordinating Post-Acute Care Act of 2015" and is also known as BACPAC Act of 2015. This bill is designed to foster the delivery of high-quality, post-acute care services in the most cost effective manner while preserving the ability of patients, with guidance from their physician, to select their preferred provider of post-acute care services. This is the type of legislation that has the potential to promote healthy competition among PAC providers on the basis of quality, cost, accountability, and customer service while advancing innovation in care coordination, medication management, and hospitalization avoidance.

I am pleased the committee is examining post-acute care issues. Proposals such as BACPAC have potential to reward quality, achieve savings, and strengthen the sustainability of the Medicare program.

I look forward to hearing from our witnesses today, and I yield back.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.
The Chairman will recognize himself for an opening statement.

Over the past several years this committee has focused on understanding and responding to the need to modernize Medicare's financing and payment structures. Today's hearing will give Members and stakeholders an opportunity to examine the current state of post-acute care (PAC) for Medicare beneficiaries and discuss ways it can be improved.

Post-acute care is care that is provided to individuals who need additional help recuperating from an acute illness or serious medical procedure, usually after discharge from hospital care.

Post-acute care providers—such as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), home health agencies (HHAs), and hospices—are reimbursed by Medicare with different payment systems which were originally designed to focus on a phase of a patient's illness in a specific site of service. As a result, payments across post-acute care settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar.

According to the Medicare Payment Advisory Commission (MedPAC), Medicare's payments to PAC providers totaled $59 billion in 2013 1A[1]. For patients who are hospitalized for exacerbations of chronic conditions, such as congestive heart failure, Medicare spends nearly as much on post-acute care and readmissions in the first 30 days after a patient is discharged, as it does for the initial hospital admission. Medicare payments for post-acute care have grown faster than most other categories of spending.

For example, total Medicare spending for patients hospitalized with myocardial infarction, congestive heart failure, or hip fracture grew by 1.5 to 2.0% each year between 1994 and 2009, while spending on post-acute care for those patients grew by 4.5 to 8.5% per year 1A[2].

There are many opportunities for the Medicare program to save taxpayers' dollars and improve seniors' quality of care through better management of post-acute care. One way is to make sure patients are treated in the most cost-effective, clinically appropriate setting.

The current model has significant reimbursement disparities for treating the same condition. For example, for patients hospitalized with congestive heart failure in 2008, Medicare paid about $2,500 in the 30 days after discharge for each patient who received home health care, as compared with $10,700 for those admitted to a SNF, and $15,000 for those cared for in a rehabilitation hospital.

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I am glad the committee is examining post-acute care issues. Proposals such as BACPAC have potential to reward quality, achieve savings, and strengthen the sustainability of the Medicare program.

I look forward to hearing from our witnesses today and yield the balance of my time to ———————————— (or to any Republican Member seeking time).

Thank you.

Mr. PITTS. And at this time, I recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for opening statement.

## OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman.

Millions of Medicare beneficiaries require continued care in post-acute settings after hospitalization. In 2013, 42 percent of Medicare beneficiaries discharged from the hospital went to post-acute care settings. Medicare spent $59 billion on these services that year.

Medicare pays each type of PAC facility at a different rate. These different rates are created under the notion that sicker patients will require more costly care in specialized facilities, which seems normal.

However, advancements in the practice of medicine as well and thoughtful analysis by MedPAC and other independent researchers call into question the wisdom of such differentiated payment rates. MedPAC has long noted that shortcomings in Medicare's fee-for-service payments for post-acute care. Just last month, MedPAC reiterated that payments for post-acute care are too generous and significant shortcomings in the current structure exists. There is broad consensus on the need for improved quality measures across the post-acute care setting and a need for a more coordinated approach to care.

Unfortunately, our current system is characterized by silos. Patient-centered coordinated care is not encouraged by the incentive structure. Yet, while there is agreement on the need to improve the way post-acute care is delivered and reimbursed, significant challenges have hindered meaningful reform. This includes a lack of uniform definitions, standardized assessment information across care settings, and substantial geographic variation. Progress has been made to address these challenges, including changes passed in the law as part of the Affordable Care Act, the IMPACT Act, and most recently H.R. 2, the Medicare Access and CHIP Reauthorization Act. The Affordable Care Act included improvements in the post-care system, acute care system. As a result, Medicare is currently piloting delivery reforms.

The Centers on Medicare and Medicaid Services is in the process of testing the concept of bundled payments for post-acute care. Bundled payments encourage accountability for cost and quality by incentivizing only clinically necessary care and enhanced coordination. This has the potential to encourage more efficient delivery, break down those silos, and facilitate care coordination.

The ACA also required home health prospective payment system to be rebased to reflect more accurate factors, such as the average cost of providing care and the mix of intensity of services. Rebasing is currently being phased in and scheduled to be fully implemented by 2017. These important steps will help move us to an improved post-acute care system for beneficiaries and taxpayers.

Last Congress, the Improved Medicare Post-Acute Care Transformation or IMPACT Act was signed into law. This legislation reflected bipartisan, bicameral, stakeholder agreement that meaningful reform must be based on standardized post-acute assessment data, also provider settings.

The collection of common post-acute patient assessment data is to determine the right setting for patients who will facilitate discussions on how to reform and improve care for beneficiaries and the Medicare system as large. Without standardized patient assessment data, reforms to base post-acute care reimbursements on patient characteristics rather than on service in setting specific payment rates will be obstructed. There is a widespread agreement that new payment and delivery sent models are necessary to improve our healthcare system and achieve better patient outcomes, population health, and lower per capita cost.

As providers and CMS are in the process of testing new models, there is still much work to do. This work is ongoing and now is the time to dedicate resources toward building the knowledge base to help our understanding and inform decisionmaking. There are many potential policies available to pursue and using the lessons learned from recent efforts is an important step. This must be done before considering large-scale adoption of reform. Simply bundling payments in advance of this work would be premature.

The Bundling and Coordination Post-Acute Act, BACPAC, takes a different approach from what MedPAC has considered. Commenting on any specific approach would preempt the results of pilots and preclude CMS from utilizing the lessons learned from IMPACT Act and pilot programs to create more effective bundle models.

I look forward to hearing our witnesses today and further debate on our post-acute care reform. And I yield back my time.

Mr. PITTS. The chair thanks the gentleman.

Now recognize the vice chairman of the subcommittee, the gentleman from Kentucky, Mr. Guthrie for 5 minutes for an opening statement.

Mr. GUTHRIE. Thank you, Mr. Chairman. I would like to yield my time to our colleague on the full committee, Mr. McKinley from West Virginia.

Mr. PITTS. The gentleman is recognized.

Ms. MCKINLEY. Well, thank you. Thank you, Congressman. And thank you, Chairman, for the opportunity to address the group today.

This legislative hearing on post-acute care and especially on H.R. 1458, this Bundling and Post-Acute Care Act. As many of you may be aware, the President has already put post-acute care bundling in his budget, and we passed it, and the House has already included in our House version of what is in the conference right now is a concept of this. So it is very important that we—it is not a new concept. It is one that we have been working together on this framework for now 3 years, both with all the stakeholders. We have been working with the committee staff and they have been incredibly supportive in trying to put together something that answers this need. But for 3 years been trying to put this—because this is going to improve care for seniors and is going to help Medicare in the long run with it.

It develops a model for post-acute care services which will increase efficiency, encourage more choice and personalized care for patients, and offer some significant savings to the program in the process. There have been some people have argued that it might cost money. To the contrary. The CBO has already issued a finding that it could save between $20 and $25 billion, with a B, for Medicare if this program were put through. Not through cuts, but through creating efficiency in the post-acute care system. A bill that innovates, improves efficiency, protects Medicare and has a pay for of $20 to $25 billion, I think it deserves meaningful consideration.

And I really applaud the committee and the chairman all for giving it consideration here today. And I yield back the balance of my time.

Mr. PITTS. Thank you.

Mr. GUTHRIE. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The chair thanks the gentleman.

Now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for opening statement.

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. Thank you, Mr. Chairman, for calling today's hearing on post-acute care delivery, and I want to thank all of our witnesses for coming to testify, but especially welcome Dr. Steven Landers from New Jersey who is the president and CEO of the Visiting Nurse Association Health Group.

The Affordable Care Act has put Medicare on a path towards post-acute reform. However, there is still much more that needs to be done. Our committee clearly has a role to play in advancing positive beneficiary-focused reforms related to post-acute care for Medicare beneficiaries. We have a Medicare system right now with misaligned incentives, inaccurately priced payments, and little information on the quality or outcomes of beneficiaries served by post-acute providers like skilled nursing facilities, home health agencies, long-term care hospitals, or inpatient rehab facilities.

In 2013, Medicare spent about $59 billion on post-acute care providers, and I believe that there are viable payment solutions in this sector that are more sensible than increasing costs for beneficiaries of average incomes of only $22,500. What we know is that the quality outcomes and costs of post-acute care has a lot of variation around the country. And as a result of the ACA, Medicare is currently testing a number of payment system reforms that help improve care and outcomes in this area. Meanwhile, the need for post-acute care is not well-defined. Research has shown the similarity of patients treated in different post-acute care settings. A patient being rehabilitated from a stroke or hip replacement can be treated in a skilled nursing facility or an inpatient rehab facility, but in the latter Medicare pays 40 to 50 percent higher than it pays the skilled nursing facility for the same services.

And we do not have any common and comparable data across PAC providers to determine which patients fare best in which settings or even what appropriate levels of care are for patients of various acuity. That is why last year Congress passed the bipartisan IMPACT Act which, for the first time, requires providers to report standardized assessment data across the various post-acute care settings. While there are many interesting policy ideas in this arena, we need to learn from the ACA efforts underway and the data being collected as a result of the IMPACT Act and provide enough time to ensure the models work in a way that doesn't compromise access to high-quality services for our beneficiaries.

Data collected by the IMPACT Act, coupled with MedPAC's recommendations that Congress could do better or could better align post-acute care incentives to better utilize Medicare dollars, should be a useful guide for our efforts. And once we have improved information on post-acute care, I look forward to working with my colleagues on the committee to find policy solutions to ensure that

Medicare continues to provide quality and effective health care to our seniors.

I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman as always.

Any written statements of the members' opening statements will be made part of the record. That concludes our opening statements.

I have a UC request. I would like to submit the following documents for the record. First, testimony from the Coalition to Preserve Rehabilitation and Orthotic and Prosthetic Alliance, and statements from the National Association For Home Care and Hospice, the Premiere Healthcare Alliance, the American Hospital Association, the American Medical Rehabilitation Providers Association, National Long-Term Hospitals, and the National Association of Chain Drugstores.

Mr. GREEN. No objection.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. We have two panels today before us. On our first panel we have Dr. Mark Miller, executive director of the Medicare Payment Advisory Commission. Thank you very much, Dr. Miller, for coming today. Your written testimony will be made part of the record. You will have 5 minutes to summarize. And, at this time, you are recognized for 5 minutes for your opening statement.

## STATEMENT OF DR. MARK E. MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MILLER. Chairman Pitts——

Mr. PITTS. Microphone. Yes. OK.

Mr. MILLER. Sorry about that.

Chairman Pitts, Ranking Member Green, distinguished committee members, thank you for asking the Medicare Payment Advisory Commission to testify today. As you know, MedPAC was created by the Congress to advise it on Medicare, and today we were asked here to talk about our work on post-acute care.

The commission's work in all instances is guided by three principles: How you assure that the beneficiary gets the access to high quality coordinated care, to protect the taxpayer dollar, and to pay plans and providers in a way to achieve those two goals. Post-acute care services are a vital part of the Medicare benefit. They provide rehabilitation and nursing services at critical points in a beneficiary's care. But I think we are all aware that there are problems, particularly in fee-for-service, that face the post-acute care.

Our siloed payment systems encourage fragmented care by paying based on setting rather than based on the needs of the beneficiary. The nature of fee-for-service reimbursement itself, encourages service following in which, in some cases, may be unnecessary. We know that if Medicare payment rates are set too high or constructed inconsistently across setting, they can result in patient selection and patterns of care that focus on revenue rather than on patient need. And for post-acute care, the clinical guidelines themselves regarding when services are needed are poorly defined. And this isn't an accusation. This is what you get when you talk to clinicians and it makes it hard for both clinicians and policymakers in this area to make policy.

So what is the commission's guidance? In the short run, the commission would set fee-for-service payment rates to reflect the efficient provider. For example, the commission's annual payment analysis has determined that payment rates for home health and skilled nursing facilities have been set too high for over a decade, and we have repeatedly recommended rebasing those rates downward to be more consistent with the cost of an efficient provider.

A commission goal is to pay the same for similar patients regardless of setting of care. For example, the commission recommended that the secretary examine paying the same base rates in inpatient rehab facilities and skilled nursing facilities for a selected set of conditions where patients appear to be similar, in other words, to have a site neutral payment.

The commission would reform payments to avoid patient selection strategies. We have recommended that CMS revise its home health and its skilled nursing facility payment systems to remove the strong incentive to take physical rehab patients and to avoid complex medical patients.

The commission has recommended policies to moderate excessive services. For example, the most rapid growth in the home health sector is utilization unrelated to a hospitalization. The commission has recommended a modest copayment for those episodes that don't follow hospitalization, and we have published data showing that there are areas of the country with excessively high utilization of home health services and encourage the secretary to use their fraud and abuse authorities to examine those areas.

The commission has also created policies that overlay fee-for-service and try to encourage coordination. For example, we have recommended readmission penalties for hospitals, skilled nursing facilities, and home health agencies that exhibit excessive readmission patterns.

We have also made longer run recommendations to create incentives to avoid unnecessary volume and to encourage collaboration across the various post-acute care providers, the commission has called on CMS to create and examine various bundling payment strategies to assess patient need, to track a patient's quality of care, and to eliminate the various payment systems for the post-acute care sector and instead have a single unified payment system. For many years, we called for a unified patient assessment instrument. Through the past efforts on the part of the CMS and as the result of the recent passage of the IMPACT Act, that work appears to be underway, but there is still a lot of work to be done here and all of us will need to be attentive to that process.

Beyond traditional fee-for-service, a well-functioning managed care program and initiatives like accountable care organizations can also create incentives to avoid unnecessary volume and encourage coordination, and the Commission has provided a range of guidance in those areas as well.

In closing, the Commission has consistently made unanimous policy recommendations to move away from a siloed payment and delivery system that undermines care coordination and instead move towards one that is focused on the beneficiary and on care coordination, but at a price the taxpayer can afford.

I look forward to your questions.

Mr. PITTS. The chair thanks the gentleman.
[The prepared statement of Mr. Miller follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

# Medicare post-acute care reforms

April 16, 2015

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives


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Chairman Pitts, Ranking Member Green, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's work on post-acute care (PAC) in Medicare.

MedPAC is a congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly.

The Commission has done extensive work on issues related to PAC, the way Medicare pays for these services, and the reforms that are needed to encourage a more patient-centered approach to match services and settings with the needs of each patient. We have considered reforms that would promote care coordination (such as readmission policies and bundled payments), gather comparable data across PAC settings, improve the accuracy of fee-for-service (FFS) payment rates, and equalize payments made for similar services. Some changes, such as changes to FFS payments or the adoption of quality measures that allow comparison among PAC sectors, could be implemented relatively quickly. Other changes, such as payment reforms that cut across settings and fundamentally alter the way we pay for PAC, would take longer to design and implement.

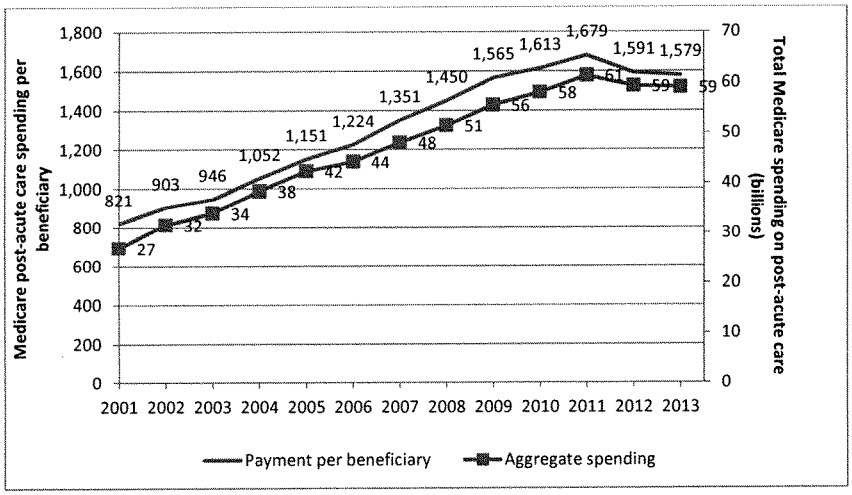
## Background

PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). PAC providers offer important recuperation and rehabilitation services to Medicare beneficiaries. In 2013, about 42 percent of Medicare beneficiaries discharged from prospective payment system (PPS) hospitals went to a PAC setting: 20 percent were discharged to a SNF, 17 percent were discharged to an HHA, 4 percent were discharged to an IRF, and 1 percent were discharged to an LTCH. Not all beneficiaries who receive PAC have a preceding hospitalization. Medicare's eligibility rules for IRFs, LTCHs, and HHAs do not require

beneficiaries to have spent time in an acute care hospital prior to receiving these services. While almost all beneficiaries admitted to IRFs and LTCHs have a prior hospital stay, two-thirds of home health episodes are admitted directly from the community. Home health episodes admitted from the community have increased more rapidly than episodes preceded by a hospitalization or PAC stay. Over the 2001–2012 period, the number of episodes not preceded by a hospitalization or PAC stay increased by 116 percent compared with a 23 percent increase in episodes that were preceded by a hospitalization or PAC stay.

In 2013, PAC FFS spending totaled $59 billion, with Medicare paying for 9.6 million PAC encounters (IRF and LTCH discharges, home health episodes, and SNF stays). PAC spending has more than doubled since 2001, from $27 billion in 2001 to $59 billion in 2013 (Figure 1). The rate of increase in spending has leveled off since 2011, consistent with a general spending slowdown in other parts of Medicare, as well as the private sector, over this time period. Per capita PAC spending has followed a similar pattern.

**Figure 1. Total and per capita Medicare spending on post-acute care have grown significantly since 2001**

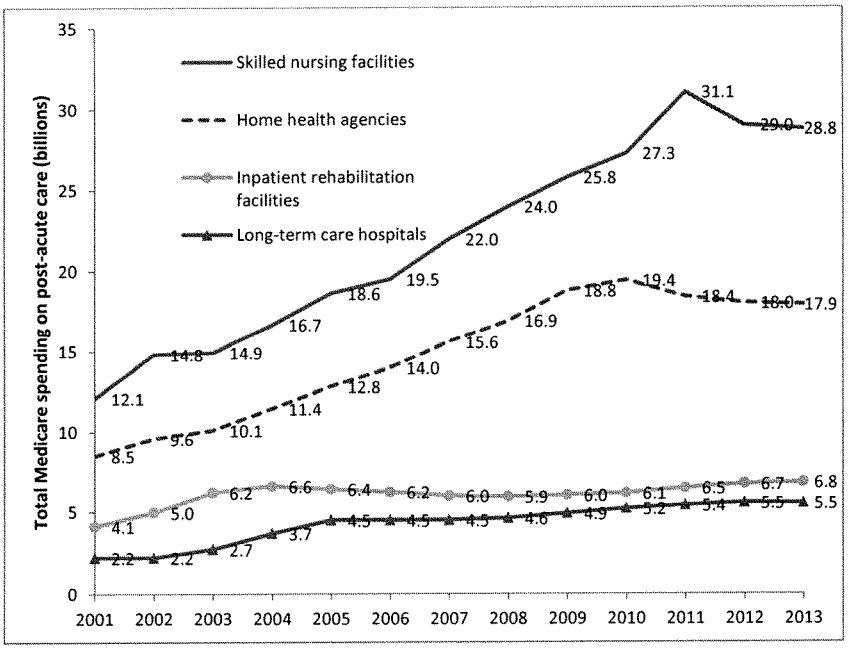



Note: These numbers are program spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary.

Figure 2 reports spending growth by sector. The Commission has documented changes in the numbers of providers, the mix of services they furnish, and the patients they treat. The intensification of rehabilitation services furnished by SNFs drove the more than two-fold increase in spending on these services. The explosive growth in the number of HHAs, the increase in the number of beneficiaries receiving home health care, and the amount of care beneficiaries receive explain the more than doubling of Medicare's spending on home health care services. Medicare payments to IRFs and LTCHs grew rapidly after these sectors adopted prospective payment systems, until other policies were put in place to control the types of cases treated in these high-cost settings. An almost 60 percent increase in the number of LTCHs during this period contributed to Medicare's increased spending in that sector.

**Figure 2. Medicare's spending on post-acute care by sector**




Note: These numbers are program spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary.

## Challenges to PAC reform

The Commission has made multiple recommendations regarding Medicare's FFS payments and quality measures for PAC and the need for a more coordinated and integrated approach to PAC. Ideally, a well-functioning PAC payment system would encourage providers and beneficiaries to develop plans of care that focus on patient needs and coordination of care. The current system of payment based on siloes discourages such patient-centered planning and coordination. However, the FFS and PAC landscapes present many challenges to reform.

First, PAC is not well defined and the need for PAC services is not always clear. Some patients can be discharged from an acute hospital stay without PAC. Others need PAC care, but similar patients receive services in varying amounts and in different settings. Still other patients may do best by staying a few more days in the acute care hospital and avoiding the transition to a PAC setting. Clinical evidence does not clearly delineate the types of patients who belong in each setting and the amount of services needed.

A lack of clear, consistent guidelines for appropriate PAC use has contributed to wide geographic variation in PAC utilization and spending. Variation in PAC service use per beneficiary is larger than for other services: PAC service use varies two-fold between low-use and high-use geographic areas, even when the most extreme low- and high-use areas are excluded. In contrast, inpatient hospital service use varies by about twenty percent (Table 1). At the extremes, the differences are even larger: PAC spending varies about eight-fold, while inpatient hospital services vary roughly 60 percent.

**Table 1. Comparison of service use variation across geographic areas**

| Ratio of high- to low-service-use areas | Inpatient hospital | Ambulatory care | Post-acute care |
|---|---|---|---|
| Areas at the 90th to 10th percentiles | 1.22 | 1.24 | 2.01 |
| Highest use to lowest use area | 1.59 | 2.01 | 7.97 |

Note: Areas are defined as metropolitan statistical areas for urban counties and rest-of-state nonmetropolitan areas for nonurban counties. Service use is measured as risk-adjusted per capita spending (adjusted for wages and special add-on payments) by sector among fee-for-service beneficiaries in each area.

Source: MedPAC analysis of 2006–2008 beneficiary-level Medicare spending from the Beneficiary Annual Summary File and Medicare inpatient claims.

There is also wide variation within a given clinical condition. Even among beneficiaries who use PAC and have similar care needs, Medicare spending on PAC varies more than three-fold between the 25th and 75th percentiles (Table 2). These spending differences reflect both the mix of PAC services (e.g., whether the beneficiary went to a SNF or an IRF) and the amount of PAC used (e.g., the number of SNF days or home health care episodes).

**Table 2. Medicare spending on post-acute care varies more than three-fold for conditions that often use these services**

| Condition | Spending on post-acute care within 30 days of hospital discharge | | | Ratio of 75th to 25th percentiles |
|---|---|---|---|---|
| | Mean | 25th percentile | 75th percentile | |
| Coronary bypass w cardiac catheterization | $5,286 | $1,864 | $6,913 | 3.7 |
| Major small & large bowel procedures | $6,100 | $2,110 | $8,804 | 4.2 |
| Major joint replacement | $8,152 | $3,890 | $11,484 | 3.0 |
| Stroke | $13,914 | $5,936 | $19,371 | 3.3 |
| Simple pneumonia & pleurisy | $7,039 | $2,351 | $10,785 | 4.6 |
| Heart failure & shock | $5,997 | $2,034 | $9,331 | 4.6 |
| Fractures of hip & pelvis | $11,688 | $8,213 | $14,427 | 1.8 |
| Kidney & urinary tract infections | $8,040 | $3,335 | $11,963 | 3.6 |
| Hip & knee procedures except major joint replacement | $13,608 | $10,526 | $16,498 | 1.6 |
| Septicemia or severe sepsis w/o MV 96+ hours | $8,282 | $3,344 | $11,744 | 3.5 |

Note: Post-acute care includes services furnished by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. We risk adjusted spending using Medicare severity-diagnosis related groups (MS-DRGs) and standardized payments for differences in wages and special payments (such as teaching, disproportionate share, and outlier payments). Data shown are for patients assigned to MS-DRG acuity level 1 (no complications or comorbidities). Spending is for care furnished within 30 days after discharge from an inpatient hospital stay. MV is mechanical ventilation.

Source: Analysis of 5 percent 2007 and 2008 claims data prepared for MedPAC by 3M Health Information Systems.

Current use patterns do not necessarily reflect how much care patients should receive or where they would best receive it because there are no financial incentives for providers to refer patients to the most efficient and effective setting. Instead, placement decisions can reflect many factors, including the availability of PAC settings in the local market, geographic proximity to PAC providers, patient and family preferences, and financial

relationships between providers (for example, a hospital may prefer to discharge patients to providers that are part of its system). Until recently, hospitals and PAC providers had little incentive to consider the cost to Medicare of a patient's total episode of care or to coordinate care across settings. As a result, providers focused on their silo of care, which may not have best served the beneficiary and may have potentially generated unnecessary costs to the program and beneficiaries. The hospital readmission penalty has begun to provide important incentives for providers to coordinate care across settings.

Another complication is that while different PAC settings treat similar patients, Medicare pays them different rates depending on the setting. For example, patients recovering from joint replacement are treated by IRFs, SNFs, and HHAs, but each setting has a different payment rate for this care. Higher payments may be warranted for a provider that produces better outcomes. However, Medicare currently lacks the necessary data to compare outcomes for similar patients treated in different settings. Without uniform information about the patients discharged from the hospital and treated in different PAC settings, it is difficult to make appropriate placement decisions and to compare costs and outcomes across settings.

### Broad reforms for post-acute care

The Commission maintains that Medicare needs to move away from FFS payment and toward integrated payment and delivery systems that are focused on the patient's needs, coordinating care, and ensuring positive outcomes. Our work on Medicare Advantage plans, accountable care organizations (ACOs), and bundled payments are examples of reforms that center payments on the beneficiary or episode of care rather than on specific services furnished in particular settings. Under these new approaches, providers are encouraged to coordinate care across settings and to furnish the lowest cost mix of services necessary to achieve the best outcomes.

Over the last several years, Medicare has begun moving toward paying providers differentially for the quality of care they provide and the success of their care coordination efforts. Readmission penalties, which began in the inpatient hospital PPS and have since expanded to SNFs (effective 2018), were an initial effort to use payment policy to encourage

better care coordination for beneficiaries. Bundling initiatives, which assign a single entity responsibility for a patient's episode of care, represent a more expansive effort to incentivize care coordination. The Commission is also beginning work on a unified PAC payment system, which would base payments on patient characteristics, rather than site of care.

**Expand readmission policies to PAC providers in FFS**

Based on analysis of the sources of variation in Medicare spending across episodes of care, in 2008 the Commission recommended that hospitals with relatively high readmission rates be penalized. As of October 2012, a readmission policy now penalizes hospitals with high readmission rates for certain conditions, and readmission rates have started to decline.

In 2011, the Commission began to examine expanding readmission policies to PAC settings to reduce unnecessary rehospitalizations and better align hospital and PAC incentives. If hospitals and PAC providers were similarly at financial risk for rehospitalizations, they would have an incentive to coordinate care between settings. Unnecessary hospital stays pose risks for beneficiaries and raise the cost of episodes. Among 10 conditions that frequently involve PAC, we found Medicare spending for episodes with potentially preventable rehospitalizations was twice as high as for episodes without them: readmissions accounted for one-third of the episode spending. Furthermore, there is large variation in readmission rates, suggesting ample opportunity for improvement. For example, SNF rehospitalization rates for five potentially avoidable conditions vary by more than 60 percent between the best and worst facilities.

Aligned readmission policies would hold PAC providers and hospitals jointly responsible for the care they furnish. In addition, the policies would discourage providers from discharging patients prematurely or without adequate patient and family education. Aligned policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality.

To increase the equity of Medicare's policies toward providers who have a role in care coordination, the Commission has recommended payments be reduced to both SNFs and

HHAs with relatively high risk-adjusted readmission rates. The proposed readmissions reduction policies would be based on providers' performance relative to a target rate. Providers with rates above the target would be subject to a reduction in their base payment rate, while providers below would not. Such an approach could encourage a significant number of providers to improve, thereby achieving savings for the Medicare program through fewer hospital readmissions. The proposed policies also seek to establish incentives for all providers to improve, without unduly penalizing providers that serve a significant share of low-income patients. To do so, providers' performance would be compared with other providers that serve a similar share of low-income patients.

The Commission recommended a SNF readmissions reduction program in its March 2012 report to the Congress. In March 2014, as part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing program beginning in fiscal year (FY) 2019, which includes readmissions and resource use measures. The home health readmissions reduction program recommendation was published in the Commission's March 2014 report to the Congress.

**Bundled payments**

Under bundled payments, Medicare would pay an entity for providing an array of services to a beneficiary over a defined period of time. In the case of PAC, the bundle could cover all PAC services following a hospitalization. This bundle design would give all the PAC settings involved in providing care an incentive to provide high quality care in the most efficient setting and to tailor the services provided to the patient's needs.

Given the wide variation in PAC use, such an approach could yield considerable savings over time by replacing inefficient and unneeded care with a more effective mix of services. Bundled payments could also give providers that are not ready or that are unable to participate in more global payment like ACOs a way to gain experience coordinating care spanning a spectrum of providers and settings, thus facilitating progress toward larger delivery system reforms.

The Commission recommended testing bundled payments for PAC services in 2008 and since then has examined a variety of bundle designs. In its June 2013 report to the Congress, the Commission described the pros and cons of key design choices in bundling PAC services: which services to include in the bundle, the duration of the bundle, how entities would be paid, and incentives to encourage more efficient provision of care. Each decision involves tradeoffs between increasing the opportunities for care coordination and requiring providers to be more accountable for care beyond what they themselves furnish.

We also laid out possible approaches to paying providers, comparing an all-inclusive payment made to one entity with continuing to pay providers FFS (like the ACO concept). Though a single payment to one entity would create stronger incentives to furnish an efficient mix of services, many providers are not ready to accept payment on behalf of others and, in turn, pay them. Alternatively, providers could continue to receive payments based on FFS. To encourage providers to keep their spending low, a risk-adjusted episode benchmark could be set for each bundle, and providers could be at risk for keeping their collective spending below it. In establishing the spending benchmarks, current FFS spending levels may not serve as reasonable benchmarks given the FFS incentives to furnish services of marginal value. The return of any difference between actual spending and the benchmark could be tied to providers meeting certain quality metrics to counter the incentive to stint on services. For beneficiaries, bundled payments should improve care coordination and reduce potentially avoidable rehospitalizations.

#### A unified PAC payment system

Because PAC can be appropriately provided in a variety of settings, Medicare ideally would pay for PAC using one payment system with payments based on patient characteristics, not on fee-for-service. A unified PAC payment system would encourage providers to focus on developing a PAC plan of care based on a patient's clinical needs, rather than identifying the most profitable setting to provide care. A critical requirement for developing a single PAC payment system is comparable assessment data across the four PAC settings.

The Commission has been discussing the need for a common assessment tool to compare PAC patients, their service use, and outcomes since 2005, and recommended the collection of common assessment items across the four PAC settings in 2014. Under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, PAC providers will begin collecting uniform assessment data in 2018. After the Secretary of Health and Human Services has collected two years of data, she is required to submit a report to the Congress recommending a uniform payment system for PAC. The IMPACT Act also requires the Commission to develop a prototype prospective payment system spanning the PAC settings and submit a report in 2016 presenting an approach for a cross-setting PAC payment system. Under a unified PAC payment system, common assessment data would be used to set a single payment rate based on a patient's conditions and characteristics. That payment would follow a patient regardless of which setting provided his or her PAC care.

### Need to maintain accurate Medicare fee-for-service payments

While broad payment reforms are needed, FFS methods remain important because they are likely to remain the dominant option for the near term. Therefore, CMS needs to continue to improve the accuracy of program payments for PAC and ensure the comparability of payments across settings when providers treat similar patients.

As required by law, each year the Commission makes recommendations regarding how payments should change for the coming year for services furnished under FFS Medicare. In making its determination, the Commission considers beneficiary access to services, the quality of care, providers' access to capital, and Medicare payments in relation to providers' costs to treat Medicare beneficiaries (referred to as the Medicare margin).

The Commission has frequently observed that Medicare's payments for PAC are too high and that its payment systems have shortcomings. The high level of payments results both from base rates that were set too high relative to the cost of a service and from weaknesses in the payment systems that encourage providers to increase payments by strategically

conducting patient assessments, increasing the amount of therapy they provide to raise payments, and selecting certain types of patients over others. There is also significant variation in financial performance within categories of providers (e.g., for-profit vs. not-for-profit, freestanding vs. hospital-based facilities). Biases in the HHA and SNF prospective payment systems make certain patients, and the services provided to them, more profitable than others. Medicare's payment incentives can therefore influence providers' decisions about which beneficiaries to admit and the care they furnish, potentially disadvantaging certain patients. For example, the home health care and SNF PPSs favor rehabilitation care over medically complex care because therapy payments are based on the amount of service furnished, and increases in therapy payments outpace increases in therapy costs.

Providers can also increase their payments by delivering more services. The SNF payment system pays on a per-day basis, which may encourage longer than necessary stays because providers can earn additional payments by keeping patients longer. The home health payment system pays per episode, rather than per day, which may create an incentive to generate additional episodes of care. Between 2002 and 2013, the total number of home health episodes increased by almost 64 percent.

The Commission believes that Medicare must concurrently refine its FFS policies while exerting pressure on providers to control their costs and be receptive to new payment methods and delivery reforms. This year, we recommended no payment updates for IRFs and LTCHs in fiscal year 2016, concluding that providers in those sectors will be able to continue to provide appropriate access to care under current payment rates. For payments to SNFs and HHAs, we reiterated our previous recommendations to lower the level of payments. In making these recommendations, the Commission considered the double-digit Medicare margins the SNF and HHA sectors have experienced for many years (Medicare margins in 2013 were 12.7 percent for HHAs and 13.1 percent for SNFs) coupled with wide spread access to and use of these services.

In addition to lowering the payment rates for HHAs and SNFs, the Commission has recommended restructuring the HHA and SNF PPSs to base Medicare's payments on patient

characteristics, not the amount of services furnished. In 2008 we recommended revising the SNF payment system to eliminate a payment bias favoring rehabilitation therapy services, and in 2011 we made a similar recommendation for the home health payment system. These recommendations, which are budget neutral, are intended to accompany the aforementioned payment rate reductions to ensure that both the level of payment and the incentives within the system are accurate and fair, and that no patients are disadvantaged by the payment system.

The Commission also assesses whether additional policies are needed to influence provider and beneficiary behavior. Given the poor definitions of PAC products and a lack of clarity regarding who needs PAC services and how much is appropriate, the sector is open to the delivery of unnecessary or low-value care. When providers tailor the amount of service they furnish to take advantage of the designs of the payment systems, they may deliver services that beneficiaries do not need. To engage beneficiaries in evaluating their use of home health care, the Commission recommended a modest copayment for home health services. The copayment would not apply to episodes preceded by a hospital stay.

Highly questionable patterns of home health care use have also led the Commission to recommend expanded medical review activities and the suspension of enrollment of new providers and payments in areas with high levels of suspected fraud and abuse. The Commission annually publishes a list of the 25 counties with the highest rates of home health utilization to draw attention to the aberrant and potentially fraudulent patterns of home health use in certain areas of the country. For example, in the county with the highest rates of home health use in 2013, 36 percent of FFS beneficiaries used home health services, 4.4 episodes were provided per home health user, and nearly 160 episodes were provided per 100 FFS beneficiaries. In contrast, nationwide in 2013, 9.3 percent of FFS beneficiaries used home health care, 1.9 episodes were provided per home health user, and 18 episodes were provided per 100 FFS beneficiaries. These high rates for select counties underscore the need for further review, as many of the high-utilization areas have appeared in our report for several years. The Commission has encouraged the Secretary to use her authority to place a

moratorium on new providers and suspend payments in areas with excessively high rates of home health use.

### Home health rebasing

Medicare implemented the first of four years of base-payment reductions in its home health PPS in 2014, as required by the Patient Protection and Affordable Care Act (PPACA). The Commission was required by law to assess the impact of these rebasing cuts on quality of care and beneficiary access. After comparing the legislated rebasing cuts with past home health rate cuts, the Commission determined that they will not harm quality of care or beneficiary access, and in fact deeper cuts are still needed to better align home health payments with costs.

To implement rebasing, CMS set an annual reduction to the home health per episode base rate for four years. However, these reductions are partially offset by annual payment updates that home health agencies will continue to receive. When both rebasing cuts and payment updates are accounted for, the annual net payment reduction is quite small—between 0.4 percent and 0.6 percent per year. Across all four years, the cumulative net reduction equals about 2 percent.

This reduction is small by historical standards; in the past, the home health base rate has been reduced by 3 percent in a given year without a measurable effect on beneficiary access and quality of care, or on HHAs' financial performance under Medicare. Historical data demonstrate that the home health industry has responded to prior payment changes in ways (e.g. reducing visit costs and altering coding practices) that sustained double-digit Medicare profit margins, averaging 17 percent over the period from 2001 and 2012. Additionally, there has been sustained entry into the Medicare program by new home health agencies over the last 13 years, despite payment changes.

The industry has projected widespread negative margins as a result of the legislated rebasing. However, these projections assume that HHAs' costs are fixed, that agencies will not make adjustments to their costs in response to changes in Medicare payments, and that future

annual cost growth will equal the market basket. In contrast, we have found that the home health industry is remarkably responsive to changes in Medicare payment policy and has historically managed to keep annual cost growth around 1 percent, which is well below the average market basket. Home health agencies' rates of visits per episode provide an example of how agencies have reacted to financial incentives in the PPS. When the original payment for home health episodes was established in 2000, it assumed that agencies would provide 32 visits per episode. Because the episode payment does not vary based on how many visits a beneficiary receives, agencies have an incentive to reduce their visits per episode in order to lower costs. Since 2000, when the initial episode rate was established, the intensity of a visit has increased, but visits per episode have declined dramatically—first to 21 in 2001 and, by 2013, to about 18 visits per episode. The episode payment was never adjusted to reflect this decline.

The Commission will continue to review access to care and quality data as rebasing is implemented. However, experience suggests that the small PPACA rebasing reductions will not change average episode payments significantly. Home health agency margins are likely to remain high under the current rebasing policy, and current quality of care and beneficiary access to care are unlikely to be hurt.

## Reforms to eliminate price differences across sites of care

Over the longer term, the Commission believes that FFS Medicare should move toward a unified payment system for PAC. In the near term, the Commission maintains that Medicare should move in the direction of uniform payments by aligning payments across settings for select conditions. Relating to PAC, the Commission has focused on payment differences between SNFs and IRFs on the one hand, and LTCHs and acute care hospitals on the other. In each case, the Commission has developed a set of criteria to identify patients with similar care needs to guide the establishment of payment policy.

### Patients with similar care needs in SNFs and IRFs

Two PAC settings in which certain groups of patients with similar care needs are treated are SNFs and IRFs. In its most recent March 2015 report to the Congress, the Commission

recommends eliminating the differences in payment rates for select conditions frequently treated in both settings. The Commission is not alone in its interest in aligning payments between IRFs and SNFs. Since 2007, administrations' proposed budgets under presidents from both parties have included proposals to narrow payment rates between IRFs and SNFs for select conditions commonly treated in both settings.

The services typically offered in IRFs and SNFs differ in important ways. IRFs are required to meet the conditions of participation for acute care hospitals, including having more nursing resources available and having care supervised by a rehabilitation physician, among other requirements. Stays in IRFs are shorter on average, and patients in IRFs receive more intensive services, in part because patients admitted must be able to tolerate and benefit from an intensive therapy program. The Commission recognizes that the services in the two settings differ; however, it questions whether the program should pay for these differences when similar patients are admitted.

The site-neutral policy doesn't apply to all patients in the SNF and IRF settings. To identify possible conditions and services for a site-neutral policy, the Commission used a consistent set of criteria. We examined conditions for which the majority of patients were treated in SNFs in markets (defined as hospital service areas) with both types of providers. In addition, we compared the risk profiles of patients treated in both settings to assess whether SNFs and IRFs treat patients of similar complexity. We also examined differences in outcomes. Ideally, we would compare risk-adjusted outcomes, but this information is not consistently available.

Using these criteria, we identified 22 conditions frequently treated in IRFs and SNFs and assessed the feasibility of paying IRFs the same rates as SNFs for these conditions. We examined the characteristics of patients admitted to SNFs and IRFs and did not find large differences: Patients' average functional status at admission, their risk scores, and their comorbidities overall did not differ substantially for these 22 conditions, and the two settings admitted similar shares of minority beneficiaries, while SNFs treated considerably higher shares of beneficiaries dually eligible for Medicare and Medicaid.

The Commission also examined differences in outcomes for patients treated in both settings. Because PAC providers do not yet collect uniform patient assessment information, it is difficult to compare risk-adjusted outcomes. Key measures (such as changes in patients' function) are not uniformly collected and cannot be adequately risk adjusted. However, neither CMS's PAC demonstration, which could compare patients across settings with the data it collected, nor other research has found consistent differences in outcomes between the two settings. Where differences in outcomes have been detected, researchers concede that the comparisons cannot fully control for selection differences between the settings.

The Commission has recommended that the Congress direct the Secretary to establish site-neutral payments between IRFs and SNFs for select conditions, using criteria such as those the Commission examined. For the selected conditions, the Commission recommends that the IRF base payment rate be set equal to the average SNF payment per discharge for each condition. The additional payments many IRFs receive for teaching programs and for treating low-income patients and high-cost outliers would not be changed by this policy. The Commission recommended that the policy be implemented over three years to give IRFs time to adjust their cost structures and to give policymakers time to monitor the effects of the change on beneficiaries and providers. As part of the policy, IRFs should be relieved from the regulations governing the intensity and mix of services for the site-neutral conditions. CMS should use its rule-making process to first propose criteria to select conditions appropriate for a site-neutral payment policy and then to identify conditions that would be subject to the site-neutral policy. In this way, the Secretary can gather input from key stakeholders.

#### Care for chronically critically ill patients in LTCHs

The Commission has also observed that LTCH patients have care needs that are similar to those of patients in acute care hospitals (many of whom go on to use lower cost PAC services). LTCHs have positioned themselves as providers of hospital-level care for long-stay chronically critically ill (CCI) patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care. However, nationwide most CCI patients are cared for in acute care hospitals and SNFs, and most LTCH patients are not CCI.

Medicare pays LTCHs under a separate PPS, with higher payment rates than those made for similar patients in the acute care hospital (approximately three to four times higher on average). There are few criteria defining LTCHs, the level of care they provide, or the patients they treat. The Commission and others have repeatedly raised concerns that the lack of meaningful criteria for admission to LTCHs means that these providers can admit less-complex patients who could be cared for in less-expensive settings, such as SNFs. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and may generate unwarranted use of LTCH services by patients who are not CCI.

The Commission has raised questions about what Medicare is purchasing with its higher LTCH payments. Studies comparing episodes of care for beneficiaries who used LTCHs with similar patients who did not failed to find a clear advantage in outcomes for LTCH users. At the same time, some studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs. Other studies have found that per episode spending may be the same or lower for the most medically complex patients who use LTCHs but not for those who are less severely ill.

To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended in its March 2014 and March 2015 reports to the Congress that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile at the point of transfer from an acute care hospital. LTCH cases that are not CCI would be paid acute care hospital rates approximately the same as MS–DRG payment rates that would have been paid if the patient had been treated in an acute care hospital in the same local market. Funds that would have been used to make payments under the LTCH payment system instead should be allocated to the IPPS outlier pool to help alleviate the cost of caring for extraordinarily costly CCI cases in acute care hospitals.

The Commission recommended that—in the absence of data on the metabolic, endocrine, physiologic, and immunological abnormalities that characterize the CCI condition—Medicare should define LTCH CCI cases as those who spent eight or more days in an intensive care unit (ICU) during an immediately preceding acute care hospital stay. The Commission also recommended that an exception to the eight-day ICU threshold be made for LTCH cases who received mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay. These types of cases are generally considered appropriate for admission to LTCHs and generally viewed as warranting higher LTCH-level payment rates.

The Congress enacted a similar, but less restrictive, policy through the Pathway for SGR Reform Act of 2013, which defined patients appropriate for the LTCH-level payment as those with a three-day ICU stay. The phase-in period for the implementation of this policy will begin in 2016.

## Conclusion

Medicare needs a range of policies to ensure the appropriate and efficient use of PAC services. In the near term, the Commission is recommending policies that ensure that program payments under PPS are commensurate with costs – a particularly important policy given the high payments for several PAC settings. In addition, Medicare can begin to move toward site-neutral payments where there is clear overlap in the services provided, such as for certain patients served by SNFs and IRFs. In the longer run, Medicare is beginning efforts to develop a common payment system that will eliminate the adverse incentives and inefficiencies resulting from multiple uncoordinated systems and focus the system on the patient's needs.

Mr. PITTS. I will begin the questioning. Recognize myself 5 minutes for that purpose.

Dr. Miller, there have been concerns raised from the home health industry that current legislative reductions in reimbursements threaten the ability of home health agencies to treat Medicare patients. In support of these arguments, they point to cost reports and other data that show profit margins that are either very low or, in some instances, negative. I think everyone wants to ensure the benefit and access to it remains strong.

Have you or your staff looked into this issue? And, if so, what have you found and do you have any recommendations for this committee?

Mr. MILLER. We have looked into it and we have reported on it for many years. Just to be very clear, at the front end of this answer, for many years, we have documented very high profit margins on Medicare patients in home health, in the 12, 13 percent range. And we stand by those numbers just to be very direct in responding to your question.

We are the ones who made the recommendations to start to rebase the rates, and there is a rebasing provision in law. We believe that rebasing provision doesn't go far enough. So I want to be clear about that. And I can take that on in further questions.

But then I think what may be—your question may be about and what other people see is numbers like 13 percent margins for Medicare, and then the home health folks will show you a margin that is 2 or 3 percent. And let me just talk you through that. One thing that you should keep in mind is is that the home health industry itself acknowledges that their margins on Medicare are as high as we say. If there are differences there, they are differences of a matter of a few points. So if you listen in on calls with their Wall Street investors and that type of thing, they acknowledge that the margins in Medicare are very high and that that is the place that, you know, a business model or a line of business that they want to attract.

The lower profit margin that you see reported involves a few things. Number one, it can involve other lines of business. So if an organization owns a home health line of business but owns a different line of business, the margin will reflect that. It can reflect lower payment rates in Medicaid and private payers, which often do pay less than Medicare and so their margins will be lower there. It can also reflect costs that Medicare doesn't recognize as allowable, such as political contributions or taxes paid in localities. So I think some of the differences between those two numbers are those types of things.

Mr. PITTS. As post-acute care providers look to innovate in their delivery model, I know that telemedicine is an issue many are focused on. In fact, it is a very important issue at our 21st Century cures discussion. And a number of members are working in a bipartisan fashion to advance the use of these technologies in the Medicare program. However, I have heard concerns that if telemedicine is not done correctly, it could lead to higher expenditures under the program without a similar increase in quality or service. What are your thoughts on that?

Mr. MILLER. I believe our view on telemedicine is that it can be a useful tool that providers—and not just home health providers—can use in order to manage a patient's care and cut down on some of the overhead expense of a face-to-face type of visit.

Our view here is that there is nothing in the payment scheme for Medicare that prevents a home health agency from using this service. And to the extent that the service makes good sense and helps them coordinate care and reduce their cost, they should be able to use that service.

I have heard—and this might be part of your question—in other settings, people have been concerned that the use of telemedicine, depending on how it is paid for—and it really does matter how it is paid for—does make it easier to generate a visit or an encounter, if you will, and that unless it is monitored, can produce payments per click, if you will, that can result in higher cost. But depending on how it is paid in home health within an episode, I am not quite sure that that problem is present.

Mr. PITTS. Well, Dr. Miller, I just wanted to personally thank you and your staff for the support you have given to this committee to its members on the issue of telemedicine. We would appreciate that continued support as we go forward. And I thank you.

And I now recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Miller, I too—and we appreciate your thoughtful examination of the post-acute care payment reforms that MedPAC has done to date.

From your testimony, it appears that the Commission has given some initial consideration of bundled payment design elements such as the scope of service covered, the time span of the care episode, and the ways to ensure quality. And there are tradeoffs between increasing opportunities for care coordination and requiring providers to accept greater risk beyond the care they furnish. As you noted, bundled payments can encourage accountability for cost and quality across the spectrum of care by incentivizing the provision of only clinically necessary and coordinated care.

A recent legislative proposal of the Bundling Act, the BACPAC, seems to take a different approach than what MedPAC has considered. In fact, BACPAC bundle assumes a third-party entity, a coordinator, that would pay PAC providers. BACPAC would also bundle post-acute care services after a patient's discharge from an acute care hospital. Conversely, MedPAC has explored global payments that would cover initial hospitalization and potentially avoidable readmissions in PAC services within the 90 days. So you are going not only from the hospital, but also to the PAC issue.

Could you discuss the pros and cons of the two different approaches, I guess?

Mr. MILLER. What I want to be clear in commenting on, MedPAC as an organization—and because we serve the various committees of Congress, I won't be making any comments pro or con on any piece of legislation.

Mr. GREEN. OK.

Mr. MILLER. So my comments here will be about what we have done on bundling and what we think about bundling. Hopefully,

none of this should be taken as either supporting or opposing a specific piece of legislation.

Mr. GREEN. OK. Well, my next question, then, wouldn't a coordinator simply add another layer of payment to the policy?

Mr. MILLER. That would depend entirely on how the coordinator is defined. So if the coordinator is one of the providers within the PAC continuum, no. If it is another provider outside of that continuum, that is decidedly a different actor. Whether it adds cost or not depends on where the money comes to pay for that coordinator whether it is paid out of savings or whether it is paid out of new dollars.

Mr. GREEN. Well, and that's the next question.

But, should Congress limit the flexibility in designing what elements of care can be bundled?

Mr. MILLER. So, I think the way I would answer that is the Commission—just to be clear, the Commission has looked at a number of different ways of structuring bundle. So whether it is attached to acute care and post-acute care, whether it is a set payment that goes to a particular entity or whether, in fact, you sort of draw a circle or a boundary around an episode and then continue to pay on a fee for service, we have talked through those and we have talked through the pros and cons of all of those.

There is, I think, a need to be thinking about these different issues, but I also think that there is a point at which there will probably be some action required by Congress in order to move the bundling concept along. I think that in the past, looking at different ways either through demonstrations in different models have not always produced crisp and timely results for people to act on.

I do want to also say—well, I will stop there.

Mr. GREEN. Well, you had mentioned a response to the chairman's questions about MedPAChas noted a number of times that post-acute care providers enjoy high margins and obviously investors notice that.

Could you talk briefly about the margins that post-acute care providers receive for Medicare payments and what this tells about the Medicare's payment for these services and if you have recommendations on how Congress should address these high margins?

Mr. MILLER. So, and again I am just going to do this at a very kind of high-glide level. You are probably talking currently about margins that are in the, let's call it 12 percent range for home health and skilled nursing facilities. Again, these are Medicare margins. You are probably in the 7 range for inpatient rehab facilities, maybe the 5 to 6 range or 6 range for long-term care hospitals. I am not sure I have that as wired in my head.

The Commission's view on these—and so, for example, in our current—our most recent March 2015 report, we recommended no update for inpatient rehab facilities and long-term care hospitals, the argument being that they can cover any increase in their input costs with the current level of funding that they are getting. And then for home health and skilled nursing facilities, we have recommended actual reductions in the rate to bring them closer to the cost of an efficient provider.

Mr. GREEN. OK. Thank you Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

Now recognizes the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. And thank you, Dr. Miller, for being here.

In your testimony, you mention that different post-acute care settings treat similar patients, but Medicare pays them different rates depending on the setting. Can you explain why this happens and how much authority CMS has to fix it compared with what is in the statute?

Mr. MILLER. Yes. I am probably going to be less helpful on the statute and what authority they have. That just may not be something I am as wired on.

Mr. GUTHRIE. OK.

Mr. MILLER. And again, I want to point out here that some of this is—the program sets these payment systems up at different points in time. I think that a post-acute care environment is a difficult environment for clinicians to operate in. It is a complicated set of decisions that have to be made.

But if somebody comes out for—let's say, out of the hospital for a given procedure, a hip replacement, let's say, depending on the circumstances of the patient, they could end up in an inpatient rehab facility. They could end up in a skilled nursing facility. They could end up in entirely a home health treatment plan. Medicare would pay differently in those different settings. And what we have begun to see—and we have seen this both on the acute care side, which we are not talking about today, and on the post-acute care side, places where we feel like we are beginning to identify overlaps of patients and we end up paying very differently for similar patients.

Now, I want to express some caution here. In the post-acute care setting, we have entered this area and we have begun to talk about what we think are similar sets of patients based on our research between the inpatient rehab setting and the skilled nursing facility setting. But by no means are we making very broad blanket statements that you can just pay the same in all of those settings. And I also want to say to, at least, one opening statement, some of the information that we get out of the IMPACT Act and the more consistent assessment of patients across settings will help to understand that problem better.

Mr. GUTHRIE. OK. And you also stated that the Commission has frequently observed that Medicare's payments for post-acute care are too high and its payment systems have shortcomings. Why do you believe the payments are too high and what are the system shortcomings?

Mr. MILLER. OK. Some of the—why are the payments too high? OK. Let me take that part. And then you said shortcoming.

Mr. GUTHRIE. And shortcomings in this payment systems.

Mr. MILLER. OK. So why are they too high? I think a couple of things go on. And by the way, some of this is good. It is just not the payment system necessarily keeping up.

So let's take home health, for example. So when the home health prospective payment system was created, there was this decision to create an episode, OK. So you had an episode of care. At that point

in time, 31 visits on average were provided during that episode of time and a payment system was based on that.

Over time, the the provision of health care in that episode has changed a lot. There is now about 21 visits provided. Now, in fairness, these visits are more skilled than the visits that used to be provided when there were 31. But even after you adjust for that, basically what it means is, is that the original base rate was set wrong. The industry responded, lowered the way that they were providing care and some of that margin was created. So, I think that is one of the issues.

Some of the shortcomings, I think, was another part of your question.

Mr. GUTHRIE. Yes. Right. On the payment systems.

Mr. MILLER. It is some of these things that we have already touched on here, the fact that you have such different payments in different settings and that clearly sets signals for providers who might say, well, there may be some advantage to go in one direction or another direction. I mean, those are some of the shortcomings.

I also think that there is a difficulty in, at least, in some of the payment systems, a clear signal to provide additional services and there is not a really good way, at least presently, to have a handle to counteract——

Mr. GUTHRIE. And I got real—just a couple of seconds.

Mr. MILLER. Sorry about that.

Mr. GUTHRIE. But the Commission, in your statement, you said the Commission studied difference in outcomes in SNFs and IFR settings but couldn't compare risk adjusted across that. Was there a reason why you couldn't do the risk adjustment?

Mr. MILLER. OK. So, really quickly because I see we are out of time here. In thinking about trying to set a base payment that is equal between skilled nursing facility and SNFs, we looked at risk scores, we looked at complications in comorbidities, we looked at functional statuses as best as possible and zeroed in on a few conditions that we think are very similar in the two settings.

One thing that is difficult—and this is why the IMPACT Act is so important—is what you really want in a perfect world is the same assessment applied to each patient so then you can truly across settings say, this patient is different than this patient and it is done on a common basis. That is not going on now.

Mr. GUTHRIE. OK. Thank you. I yield back.

Mr. MILLER. Sorry about the time.

Mr. PITTS. The chair thanks you. Gentlemen now recognizes the ranking member for the full subcommittee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. And I thank you for having this hearing because I think it is very important.

But, Dr. Miller, I was very impressed with the statements you have made so far because you really have been kind of urging caution in terms of how we proceed. And you have also talked about getting more information from the IMPACT Act, which is what I would like to see before we move ahead with any particular legislation.

I am just going to use an example with my dad. My dad is 91. He has been in and out of hospitals many times and, I guess, my fear in hearing some of the statements that have been made about having a PAC coordinator who is somehow going to benefit, either he or those who he services are going to benefit from some sort of pay back if—depending on where the patient is placed and this idea of just a 4 percent cut overall. These things concern me a great deal.

Let me just give you an example. Many times when my father has come out of the hospital, for whatever reason, we have to make a decision, I say "we," I mean collectively my brother, my father, myself—about where to place him. And that may be that he goes home and he gets home health care, or he goes and gets home health care for a few weeks and then he goes to the outpatient rehab facility or he may go to a inpatient rehab hospital, or he may go to a nursing home. It has often been a combination of those things, depending on what he was in the hospital for and what we think as a family is the best way to deal with that post-acute care.

And a lot of times, those are individual decisions because there is great variation. Sometimes we don't like the inpatient hospital because we don't think they do a good job or we don't like the nursing home that has been proposed because we think it is not a very good nursing home. And I would hate to think that those decisions would be made by some coordinator that I understand you would have input into. But I would be very concerned that those decisions are being made by some, you know, third party who has some sort of financial incentive to make that decision.

So I just think that we have got to be extremely careful with these things because there is such great variation, not only in terms of nursing home versus home health or nursing home versus inpatient hospital, but the individual places. In my opinion, whether I think the nursing home or the inpatient rehab facility is better than one or the other has more to do with it than it does about whether I go to a nursing home, per se.

So, let me just ask you some questions about IMPACT. Given that the Medicare program spent $59 billion on post-acute care in 2013, I am amazed we don't have better information about patient outcome service user quality of care, and it is my understanding that the IMPACT Act will address some of these information shortfalls. You want to comment a little more on that? Does IMPACT think the data gathered as a result of the IMPACT Act will be enough to move us forward? Does Congress need to do more to gather this information? And what is your general feeling about whether we should be getting more information before we make decisions about bundling or cutting Medicare payments?

Mr. MILLER. OK. You said a lot in there.

Mr. PALLONE. I know. I can spend the whole day on this because I deal with it every day. I am going to be dealing with it in an hour—as soon as I leave this hearing.

Mr. MILLER. I know. I have a father, I have an aunt that I am managing. I know exactly what you are up to.

So, let me try and do this rationally. First of all—because there are a couple of things I do want to comment on. First of all, the Commission for many years was calling for something like what

happened in the IMPACT Act and moved to a common assessment instrument. And we do think that the common assessment instrument and what goes on in the IMPACT Act—again, we haven't precisely seen what will come out of that. The legislation has set things in process and things will have to be defined in regulation. But we do think that it will do a lot of good in terms of having common domains, having common assessment scales and definitions and timeframes and the list could go on. I don't want to say it is perfect—we haven't seen exactly what will come out of it—and that there is nothing else that will be needed.

But in this area—and this is a point that I would make—I think like many things in life and in Medicare, there is movement with caution, but movement. Because the other thing that I would just, by matter of degree say back, is if we wait for everything, you know, all the demonstrations to be finished, all the incentives to be produced in perfection, we won't move forward. And that has happened in the past. And I think the Commission believed there is some ability to move forward with caution.

And here is the kinds of cautions I would say. Things like being sure that you have a transition built in so that the providers and the beneficiaries can respond. Be sure—and to some points that you were making about your own circumstances, that the person who—because one thing about a person who thinks about the entire episode, they can—if well motivated, can actually help the family make those decisions. Because I have stood in the hospital, too, had somebody say here is a list, make up your mind, what do you want to do? And you don't have a lot of sense of what to do.

Mr. GUTHRIE [presiding]. Thank you, Doctor. This is all, I mean, very good. And I appreciate what you are doing, but we are going to try to get some questions in before votes.

Mr. MILLER. All right.

Mr. GUTHRIE. So I appreciate that.

Mr. MILLER. Sorry I took so long.

Mr. GUTHRIE. And you did—it is a great discussion.

Mr. Shimkus from Illinois is recognized.

Mr. SHIMKUS. Well, that is OK, because I am very curious about the response and some of my questions were involved with that. Because, I think, following up on Mr. Pallone's questions, sometimes, in essence—I don't know the right terminology—but an advocate or someone else who could give some advice on the options from a practical application. The challenge is you are given a list, pick one, and you don't have anybody to help you through that.

So, I am on the flip side. I am not sure that it costs more. I think it may save more in time, effort, energy, and frustrations, with more information as someone who is doing that on a day—someone who is doing that on a day-to-day basis.

I think the challenge of folks our age with older adults is that we don't have the experience, and then we get thrown into it based upon an event and we are still juggling our lives, too. So, do you want to—and you were going to answer and follow up on that so go ahead.

Mr. MILLER. So I don't want to cause a nuclear reaction here——

Mr. SHIMKUS. Oh, this is the Energy and Commerce Committee. We like that.

Mr. MILLER. You are both right. OK. And I think the concern Mr. Pallone was mentioning is, is you don't want somebody making that decision too aggressively——

Mr. SHIMKUS. Right.

Mr. MILLER [continuing]. For the wrong reasons to save money. But on the other hand, if you can structure the payment system in such a way and you have risk adjusted carefully for the differences in the patient, you have quality metrics so that if a person chooses to stint in order to save, then that is a problem. So you want this person who is giving the guidance to have motivation to make sure that the person gets the highest quality care and to avoid unnecessary services.

I think both of you can be right on this matter, but you don't want to tip too far——

Mr. SHIMKUS. No. And I understand that.

Mr. MILLER [continuing]. In one way or the other.

Mr. SHIMKUS. And I appreciate that.

The other part of the questions that we have had before is about necessary data, how long do you wait before you start moving forward. What data do you think is necessary and needed for additional reform before additional reforms are adopted? So what data is not out there that you think you need to have?

Mr. MILLER. Well, here is what I would say. First of all, again, I want to say that the Commission had lots of pushing for many years on what ultimately ended up in the IMPACT Act. We think it is a good start. And so a lot of that information should be helpful. And just because I am probably not loaded enough to give you what data we are missing, I would say this: The other thing we can be thinking about is there are sets of recommendations that we have made that we can do now, that don't involve bundling, which is not to disparage bundling at all. And you can think of less aggressive versions of bundling to start moving the providers in that direction.

So think of the notion of saying I am going to define an episode of care. I am going to continue to pay on a fee-for-service basis and there are various mechanisms you can put in place to be sure that you don't overpay, and then the providers are beginning to move to the bundle concept without actually having a hard, in-place, here-is-the-boundaries, here-is-the-payment kind of bundle. And I would encourage that because that will produce information as well.

Mr. SHIMKUS. So let me follow. I mean, you are right. It is like we choreographed this a little bit, which we did not——

Mr. MILLER. We did not.

Mr. SHIMKUS [continuing]. For the record.

Mr. MILLER. I have never seen you before.

Mr. SHIMKUS. But how should CMS or Congress, then, accomplish the recommendation of this? I mean, so you are saying we should, so how should we or CMS?

Mr. MILLER. Yes. So, I mean, the kinds of things, I think, the Commission would say is you should keep work going on looking at bundling and more of the structure types of approaches to bundling that, I think, some people are talking about, but at the same time also be thinking about mechanisms that begin to bring pro-

viders together. Some of them are more rudimentary, such as saying, if there is a lot of readmissions here across this set of providers, all of you are going to feel an effect. And so you are not saying you are in a bundle, you are not being paid by a single entity. But, if my actions result in a readmission, you and I are both going to feel it. Those types of things, and we have recommended on that front.

And then the other thought that I am trying to get across—but I am not sure I am doing it particularly well—is begin to say to that set of actors, I am now going to start looking—I am making this up—we are now going to look at what happens over 60 days in a totality type of way and if you, in terms of outcomes and payments, if you do well or do poorly, your payments will be affected that way. In a sense, it is like injecting the ACO or the Accountable Care Organization concept——

Mr. SHIMKUS. Right. Right.

Mr. MILLER [continuing]. Into more of the episode concept, if you will.

Sorry if I took too much time.

Mr. SHIMKUS. No. Good.

Mr. GUTHRIE. Thank you. The chair now recognizes Dr. Schrader from—or Dr. Schrader from Oregon for 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman. Appreciate that. You know, I do some of this post-acute care myself, but I am a veterinarian. So it is a little easier to do that way.

Along those lines, I guess, a question I have—looking at the IMPACT Act reviewing, I mean, that is a long-term project potentially and I am not sure we want to wait until 2024 whenever all that is done.

Is there some earlier date by which the committee or Congress should be informed by some of the information we are gleaning that you think would give us an opportunity to move forward in a very thoughtful way on this bundle payments thing?

Mr. MILLER. Yes. Unfortunately, we have a couple of mandated reports as a result of the IMPACT Act, and one of them is on a very short timeframe, and so hopefully we can give you some sense there, out of that report.

Mr. SCHRADER. And what is that timeframe again?

Mr. MILLER. Next summer, I am disappointed to say.

Mr. SCHRADER. Next summer. OK. OK. And then you have been talking about margins quite a bit. How are you calculating those margins? In other words, if I go to my skilled nursing facility or rehab group, are they going to agree with your assessment of the margins out there?

Mr. MILLER. No, they are not——

Mr. SCHRADER. And why would that be?

Mr. MILLER [continuing]. To answer your direct question.

I'm sorry. I shouldn't be facetious. I don't think our margins are mysterious at all. They come out of the Medicare cost reports that your skilled nursing facility or whomever else, home health agency, fills out. There are rules about what costs and how they are allocated, and then we calculate the cost and then we calculate the payments that a facility——

Mr. SCHRADER. And how is theirs going to be different? You know, when they are calculating their margins, how are they going to be different than what the model you are using?

Mr. MILLER. Well, what home health and the skilled—well, what the skilled nursing facility argument goes like this. This is the most common argument, OK. We recognize that Medicare margins are in the range that MedPAC says, 11 or 12 percent, but Medicaid and the private sector are paying us less. We are not earning as much money there. Our margins are much lower and, I think, the total margin is something like in a 2 percent range there. And then they say, you should pay more because you are basically cross-subsidizing these other payers.

The Commission's position on that is you are the Congress of the United States, you control the pursestrings, you can decide how dollars are allocated, but you should be clearly conscious that what you are doing is saying, this Medicare dollar is now subsiding dollars in the States or in the private sector and we think that that is, you know, at least a big question that should be faced head on.

Mr. SCHRADER. All right. In the ACA, there were some demonstration projects on bundled payments and that it included, not just acute care, but some of the skilled nursing. You indicated, I think, that that was kind of a token. What are we learning from that, if anything, and if——

Mr. MILLER. Right.

Mr. SCHRADER [continuing]. It is not giving us the information we want, what should we be asking to get from what we are doing hopefully in the near future?

Mr. MILLER. Yes. And the second part of your question—or this question I probably want to think about a little bit more. But what I guess I am concerned about—and you did pick up on this. So, for example, in the bundling demonstration, there were many thousands of actors who said, "I am interested in understanding my experience in bundling." And then it comes to the second phase that says and "How many of you would be willing to take risk?" And that drops immediately to the hundreds, OK, or even the 100.

Then it says, "Which of the conditions are you willing to be at risk for?" And that comes to two or three. And so, in a sense, you had, "I am really interested in looking at this." How much risk would you be willing to take risk and then for what? And then you are down to relatively small numbers. And my concern—and I think the Commission's concern—is this process isn't going to produce a very clear set of models and a clear set of generalities to say, OK, here is the direction to go.

And I think what the Commission needs to do is, given that environment, try and bring the committees of jurisdiction some structure in order to say what do you do if that information doesn't arrive in a very crisp and clear way.

Mr. SCHRADER. Real quick. And you may not be able to answer it in time. But it seems like with the Accountable Care Organizations or, in my state, the Coordinated Care Organizations, they are willing to take a lot of risk. Can't they deal with the bundled payments also for post-acute care as well as acute care? Do we need another organization or outfit to do this?

Mr. MILLER. This is a really good question. And part of the reason the Commission on the bundling front—I am going to answer this in the time. Well, apparently not.

But either way, this is a really good question because the Commission has two different views on this. Some people say—and not just the Commission—why not move to more of a population-based model, like an Accountable Care Organization, and then maybe the episodes continue as a payment mechanism in those, but maybe they are superseded by the fact that you actually have a population model management.

Mr. SCHRADER. Yes. OK. Thank you.

And I yield back.

Mr. GUTHRIE. Thank you. Gentleman yields back.

The chair recognizes Dr. Murphy from Pennsylvania for 5 minutes.

Mr. MURPHY. Thank you. Welcome, Dr. Miller. It is good to have you here.

What MedPAC has looked at and what we are talking about here are patients with a similar clinical condition receiving similar treatments from different providers at different locations for different costs. Am I correct?

OK. So has MedPAC ever looked at the issue of patients in a different way, the same clinical conditions, receiving the same treatment from the same provider at the same location for different costs?

If you would like to—I can give you a little more detail. Would you like some more details first?

Mr. MILLER. Yes. I am definitely trying to hear you.

Mr. MURPHY. OK. I put anecdotally about cases where a patient received, for example, chemotherapy from a physician that was billed as a physician-based practice.

Mr. MILLER. OK.

Mr. MURPHY. And then that same patient was seen by the same doctor, for the same treatment, at the same location and was billed as hospital outpatient treatment at an incredible markup price after that office became part of a larger healthcare system. Are you familiar with that?

Mr. MILLER. Oh, yes.

Mr. MURPHY. How widespread is this practice?

Mr. MILLER. OK. We have looked at this. I can't give you just a flat out number, here is how widespread this is. However, we have looked at specific sets of services, not the one you have raised, but specific sets of services and seen the shift in billing basically from the physician office stream to the outpatient stream and it is as you describe. I am going to the same physician office I went to, I am seeing the same set of physicians, I am getting the same service and now the bill is being run through a different payment system, the outpatient hospital payment system, because the hospital has acquired the practice and the markups can be very—or the payment increases can be very high and, of course, the beneficiary's copayment goes up commensurately with that.

Mr. MURPHY. Precisely.

Mr. MILLER. We made two recommendations in this area on sets of services that we identified, and they met certain criteria which

I won't take you through because of time and all of that. Because, again, we wanted to be careful that we didn't undercut the hospital's mission, but at the same time this particular phenomenon, we felt, was not good for the taxpayer, not good for the beneficiary particularly when we are talking about the same service, same provider.

Mr. MURPHY. Sure. So we have heard examples, for example, where someone was getting oncology treatment, chemotherapy, that, in one instance, may cost $10,000. When the hospital acquires the practice, it is billed at $30,000.

Mr. MILLER. I am—yes.

Mr. MURPHY. We have heard similar things for a dermatological procedure, et cetera. And then a person's copay may have a several thousand dollar difference as well. So it currently is legal. Am I correct?

Mr. MILLER. Yes.

Mr. MURPHY. Is it ethical?

Mr. MILLER. The Commission has raised great concerns with this practice.

Mr. MURPHY. Do you wonder if it is ethical?

Mr. MILLER. Say it again.

Mr. MURPHY. Is it ethical that someone has found this loophole and is——

Mr. MILLER. I will speak only for myself, not the 17 commissioners, OK. No. I see this as a problem.

Mr. MURPHY. Thank you.

So, previous MedPAC analysis has shown that hospital-based reimbursements is much higher, as we said, and paying the doctor more than a nonhospital affiliated facility.

Mr. MILLER. I'm sorry. Would you——

Mr. MURPHY. Sure. I have a cold, and so it is hard for me to——

Mr. MILLER. I apologize.

Mr. MURPHY. That is OK. I am sick. But what am I going to do? See a doctor?

Mr. MILLER. And I am a little nervous.

Mr. MURPHY. Anyways.

So I am paying the doctor more and charging a senior more for same service at a nonhospital affiliated facility. Can you comment on what degree a similar dynamic is differentiated payments? You may be operating in the post-acute space and its relationship to costs for seniors and potential consolidation of treatment facilities similar to those we have seen in the cancer setting.

Mr. MILLER. I now do understand what you are saying, and often the beneficiary difference in the post-acute care setting is not as extreme as you see in the acute care setting. So in the acute care setting when somebody—and this is why, when you asked your very pointed question, I see problems here. The beneficiary is paying 20 percent of whatever happens, as a general rule.

In the post-acute care setting, it is a little bit murkier. So let's take—and actually it may not be as much of an issue for the beneficiary. Let's take the inpatient rehab facility and the skilled nursing facility. The beneficiaries generally retire their in patient admission deductible and they go to these facilities. Unless they stay for long periods of times, they don't necessarily have a copayment

that goes along with it. So the circumstances are actually just a little bit more—a little less—they are not as consistent as you see on the acute care side.

Mr. MURPHY. OK. Thank you. I know I am out of time, but I just hope we continue to work with you to get more information on that process I spoke about, what those net costs may be costing Medicare as well as seniors with copays. I am sure as you go through this—and Mr. Chairman, I hope we can get that information and report that back.

Mr. GUTHRIE [presiding]. Thank you. The gentleman's time is expired. We are really pushing votes. Let me recognize the gentlelady from California, Ms. Matsui.

Ms. MATSUI. Thank you, Mr. Chairman. And Dr. Miller, thank you very much for your testimony. This is somewhat similar but not really talking about hospitals here to Dr. Murphy's questions.

Under the current Medicare payment systems, there are no financial incentives for hospitals to refer patients to the most efficient or effective setting so that patients receive the most optimal but lowest cost care. Whether a patient goes to a home health agency or a skilled nursing facility, for example, seems to depend more on the availability of the post-acute care settings and their local market, patient and family preferences or financial relationships between providers.

Now, putting aside what Dr. Murphy was concerned about, and I think we all should be concerned about that, but if we proactively look at this, since patients and also, too, the hospitals have a role in this because they don't want the readmittance either, so look at that, too, but since patients often access post-acute care after a stay in the hospital, how can we best harness the hospitals to help ensure patients receive care in the right setting after a hospital stay?

Mr. MILLER. OK. I think there is a couple of things to say here. Number 1, there is, I think, one of the reasons the Commission said there should be—and part of the problem of making a bad referral is, is that the patient had some complication or bed sore or something and bounces back.

Ms. MATSUI. Right.

Mr. MILLER. And so one of the reasons that the Commission, I think, took this position of the hospital, the skilled nursing facility, and the home health should all feel a readmissions penalty if a readmission occurs, is to try and build in—the hospital needs to be conscious of it but also the hospital's partners——

Ms. MATSUI. Partners.

Mr. MILLER [continuing]. Or implicit partners should be conscious as well to try and militate against that.

A second thing that goes on is there is something called the Medicare spending payment per beneficiary. This is a very arcane thing, but it is buried deep in the value-based performance metrics that hospitals are judged by, and so to the extent that that has some impact on their payment, they are paying attention to the 30 days that followed the discharge. But there again, if you are a hospital, you sort of say, you are holding me responsible, but there is all these other actors, how do we bring them into it.

And that is what gets us to some of the things that we are discussing today, whether you start thinking about payments affects that cut across like what I will call loose bundles or hard bundles, depending on what kind of model we are talking about, and then of course the level above that is if there is an accountable care organization that the hospital is a part of——

Ms. MATSUI. Right.

Mr. MILLER [continuing]. Then obviously it has those incentives kind of built into that.

Ms. MATSUI. So we are taking those steps now to have the responsibility sort of be more than implicit in a sense.

Mr. MILLER. I think there are still steps to be taken, but absolutely. So, for example, the Congress has implemented readmission penalties for hospitals and skilled nursing facilities but not home health.

Ms. MATSUI. Exactly.

Mr. MILLER. My understanding is home health and the skilled nursing facility, or associations and environments agree that there should be readmission penalties. The details——

Ms. MATSUI. The devil is in the detail.

Mr. MILLER [continuing]. We probably disagree on but that would be usual.

And then there are—I also want you to know this. And actually the whole committee to know this. There are discussions in the Commission. These are very—it is public. It is in the transcript, but we haven't jelled on it of, should there be some greater steering on the part of the hospital if the provider is being steered to have high quality rankings, that type.

Ms. MATSUI. That is what I was——

Mr. MILLER. I kind of thought you were going there.

Ms. MATSUI. Yes, going toward. I have quickly, another question. What about those beneficiaries that access post-acute care without a hospital stay?

Mr. MILLER. There is something of a different ballgame there.

Ms. MATSUI. Yes.

Mr. MILLER. The community admits are sometime—the words there. There is something of a different ballgame there in the sense of that beneficiary, it's potentially more difficult for the program to figure out whether we have a needed service there because the person doing the admitting—I don't want to overstate this, but the person doing the admitting in some instances is the person who is going to benefit from the admission in terms of the provider.

Now, you can be referred by community physicians, of course, but there are also decisions made by the particular provider to take a person in to continue to add episodes of care, for example, in a home health setting.

Ms. MATSUI. OK.

Mr. MILLER. And so I think some of the things we might need to think about there is whether the beneficiary bears some small portion of the cost so that the decision is not just completely open-ended to the beneficiary.

Ms. MATSUI. Sure.

Mr. MILLER. And whether there needs to be some ability to look at prior authorization, that type of thing.

Ms. MATSUI. OK. Well, thank you very much, Dr. Miller. My time is up. Thank you.

Mr. GUTHRIE. Thank you. The gentlelady yields. Be advised we are in votes now, so we will probably be able to get to one more 5-minute set of questions. Then we will reconvene following votes, probably about 12:15 we walk off the floor.

Mr. Griffith, from Virginia.

Mr. GRIFFITH. Thanks. And I will try to be brief.

And I am going to go off on a little bit of a tangent. When I was in the Virginia State legislature and then subsequent to that, North Carolina, adopted zoning requirements that would allow med cottages to be placed in somebody's back yard if a member of their family had medical needs that required two or more procedures a day. And the estimates were that this would save a lot of money. Of course, it is not paid for by the Federal Government at this time.

And I would just ask that you all look into it because the concept is, is that you would build a hospital room in a mobile facility—basically the mobile home manufacturers love the bill for that reason because they would get this, but it would allow somebody like myself, if I were to suddenly have a major problem to stay in with my loved ones. And we had testimony in Virginia at the time that there was a young man who was 8 or 9 years old who was dying and his parents wanted to be with him, but they couldn't get a medically appropriate place for him in his rural community, and so the parents had to both quit their jobs and spend the last few months with him in a hospital room in Charlottesville, Virginia.

I think this is a concept that both saves money and is compassionate. It helps patients stay with their loved ones if they can, not necessarily in the hospital, but where they can have some treatment brought to the home where that is possible, in lieu of having a nursing home bed perhaps, but with the number of nursing home folks shouldn't be too opposed to it, and weren't at the time, because they see the market expanding so much that this niche would be there.

Just ask you to think about it. I think it is something for the future, and I would appreciate it if you all would take a look at this concept and be happy to give you any information that you need.

Mr. MILLER. OK. I appreciate that.

Mr. GRIFFITH. And with that, Mr. Chairman, and many questions already having been asked and answered, I yield back.

Mr. GUTHRIE. Thank you. Yield back. And since you yield back some time, I am going to recognize the gentlelady from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman.

Dr. Miller, whenever we are talking about payment reform, I am always concerned that we are appropriately accounting for the complexities and differences among patients. I believe that if we move forward to reform in the post-acute care setting, we should be looking to make sure that we appropriately adjust provider payments to reflect beneficiary risk. Every—and personal conditions, and it kind of follows on what Mr. Guthrie was asking about.

Could you give us a—quickly, a little greater detail, do you believe a risk adjustment is an appropriate issue to focus on and

what steps do we need to take, for example, in developing a bundled payment that would appropriately account for differences in beneficiaries?

Mr. MILLER. I do think it is an incredibly important point. I think—and regardless of what kind of payment system we are talking about, you need to get the risk—you need to get risk adjustment straight so that providers don't have an incentive to avoid the most complex patients. And a lot of our work has been focused on that in different settings of trying to adjust the risk and the payment systems to fix those very kinds of problems. And so you do need it.

I think again, the data that will come through the IMPACT Act will help, but we are not completely without abilities to do that now. And one—I want to say one other thing before I say that. The other thing you want to do to help mitigate risk is have quality metrics so that if you really don't treat a patient well, the signal comes back through your payment, and then also you can do it through insurance functions, things like this.

It is an episode payment, but if you have an outlier, then there will be a payment that comes in behind that. So that the person realizes a patient is going south or potentially could go south, they aren't completely exposed to that. And that also helps them make more willing to take the complicated patient.

So I think, in answering your question, risk, absolutely important, don't forget, and I know you haven't, but quality feeds into that, and then an insurance structure in addition to that like an outlier payment all helps try and mitigate the concern which I think is you don't want them avoiding the most complicated patients. And I think there are bundles of mechanisms you can kind of think about. Anyway, I will stop.

Ms. CASTOR. Thank you.

Mr. GUTHRIE. Thank you. The gentlelady yields back. And I believe we concluded the questions for the first panel, but the committee will recess, and once we recess, we will reconvene following the last vote, and we will commence with the second panel at that—we will begin with the second panel at that time. The committee is in recess until call of the chair after the final vote.

[Recess.]

Mr. PITTS [presiding]. Ladies and gentlemen, if you will take your seats, we will get started. Thank you very much for your patience with the vote, and then before that, I had to duck out for the signing, the enrollment ceremony for the SGR which is a nice little celebration.

So, we are back now with the second panel, and I will introduce them in the order that they speak. Dr. Steven Landers, president and CEO of the Visiting Nurse Association Health Group, Dr. Samuel Hammerman, chief medical officer of the LTACH Hospital Division at Select Medical Corporation, Dr. Melissa Morley, program manager of health care financing and payment at FTI International, and Mr. Leonard Russ, principal partner at Bayberry Health Care and chairman of the American Health Care Association.

Thank you each for coming. Your written testimony will be made part of the record. You will each be given 5 minutes to summarize your testimony.

And we will begin with you, Dr. Landers. You are recognized for 5 minutes for your opening statement.

**STATEMENTS OF DR. STEVEN LANDERS, MPH, PRESIDENT AND CEO, VISITING NURSE ASSOCIATION HEALTH GROUP; DR. SAMUEL HAMMERMAN, CHIEF MEDICAL OFFICER, LTACH HOSPITAL DIVISION, SELECT MEDICAL CORPORATION; MELISSA MORLEY, PH.D., PROGRAM MANAGER, HEALTH CARE FINANCING AND PAYMENT, RTI INTERNATIONAL; AND MR. LEONARD RUSS, PRINCIPLE PARTNER, BAYBERRY HEALTH CARE, CHAIRMAN OF AMERICAN HEALTH CARE ASSOCIATION**

**STATEMENT OF DR. STEVEN LANDERS**

Dr. LANDERS. Thank you, Chairman Pitts, Mr. Shrader. Thank you, Mr. McKinley for your leadership on this issue and honored to be here with my home State Representative Pallone.

Today's hearing is timely and needed. Seniors are being discharged from America's hospitals and finding themselves often in a poorly coordinated and costly post-acute care continuum. Sometimes instead of order, there is disarray. Instead of teamwork and clear care paths across venues, there is fragmentation and confusion. Instead of efficiency, unnecessary costs are being borne by patients in the Medicare program.

My organization, VNA Health Group, serves some of the oldest and frailest Medicare beneficiaries. As a result, we have seen firsthand how bewildering and burdensome the current situation can be for ailing seniors and their families. I think of an example, Patient Mrs. Smith, an 82-year-old woman with arthritis, congestive heart failure, and low vision, being discharged from a hospital where she had recently been treated for a broken hip caused by a fall. She has received some information but is still in pain and sleepy, and she and her family aren't sure of what to do. Her daughter, her main care giver, isn't sure who is going to be in charge after she is discharged and who to go to with questions.

Mrs. Smith and people like her have some basic but important needs, including a comprehensive and holistic assessment of her post-hospital needs and circumstances, help accessing the care that she needs that is right for her condition, the support of a cadre of professionals like nurses and therapists and social workers and physicians, short-term assistance with activities of daily living and basic living nutrition. Her story is not atypical. People like her are being discharged from hospitals each day across our country. They are our parents, our grandparents, aunts and uncles, and soon they may be us.

If Mrs. Smith and seniors like her receive the coordinated care that they need, they will recuperate more quickly at a lower cost with lower risk of rehospitalization, but too often this isn't the case, and people aren't getting this type of care. Older Americans like Mrs. Smith don't have what they need most, which is patient-centered care coordination. This means having a partner that is truly

invested in helping them get better soon, a physician and nursing team by their side across care venues, integrated electronic information systems that will help avoid adverse events.

We believe that patient-centered care coordination can be achieved through PAC bundling that adapts a successful DRG model and provides consistent coordination and navigation support to discharge beneficiaries and their families. It is for this reason that the Partnership for Home Health—for Quality Home Health is proud to support the BACPAC Act. The BACPAC model incorporates elements that we feel are important to patient-centered care coordination. A model on diagnostic related groups, which have been in use for over 30 years, creates condition related groups to align interests and improve outcomes, ensures patient choice, network adequacy, and the use of clinical and technological innovations to improve care. It uses powerful risk and saving incentives to prioritize high quality coordinated care, and it strengthens program integrity because no coordinator is going to want a bad or fraudulent actor to be in its network. It aligns with Congress' passage of the IMPACT Act, which created a unified PAC assessment tool and achieves significant savings without cutting any providers' rates or increase in costs for any seniors.

There are many complex issues to be addressed, and as you do, please keep seniors like Mrs. Smith in mind so that Medicare post-acute care policy will not only be improved but work for the most vulnerable among us. Thank you.

Mr. PITTS. The chair thanks the gentleman.

[The statement of Mr. Landers follows:]

**House Committee on Energy & Commerce – Subcommittee on Health**
**"Medicare Post Acute Care Delivery and Options to Improve It"**
Thursday, April 16, 2015 – 2322 Rayburn House Office Building

**Testimony of Dr. Steven Landers, MD, MPH**
**President & CEO, VNA Health Group**

Good Morning Chairman Pitts, Ranking Member Green and Distinguished Members of the House Subcommittee of Health. My name is Dr. Steven Landers, and I serve as the President and CEO of the Visiting Nurse Association (VNA) Health Group. I am grateful for this opportunity to be with you today to discuss the current state of – and possible reforms to – Medicare post acute care.

By way of brief background, I am a family doctor and geriatrician, with a particular focus on the delivery of general primary care and palliative care to the elderly in their homes. Following my educational training at Case Western Reserve University School of Medicine and Johns Hopkins University School of Hygiene and Public Health, I served as Director of the Center for Home Care and Community Rehabilitation and Director of Post-Acute Operations for the Cleveland Clinic. I am board certified in Family Medicine with additional certificates in geriatric medicine and hospice and palliative medicine.

In 2012, I joined the outstanding team at VNA Health Group, the largest not-for-profit home health care provider in New Jersey and the second largest in the nation. For more than 100 years, our organization has served the most vulnerable amongst us — welcoming fragile new babies home, assisting disabled children and their parents, serving traumatically injured adults, delivering complex, specialized nursing services to seniors in the homes, and extending comfort to the terminally ill.

Today, VNAHG serves more than 100,000 individuals annually throughout New Jersey, a privilege we approach in a manner consistent with our tradition of collaboration and connectedness. Since our founding in 1912, our focus has been to serve those who are most vulnerable, through illness or social circumstance, in order that they may have a healthier, more hopeful, and dignified life.

I also serve on the Board of the Partnership for Quality Home Healthcare, which I am proud to represent here today. The Partnership is a coalition of leading home healthcare providers dedicated to advancing solutions that improve outcomes for all home health patients as well as greater efficiency and stronger program integrity requirements for the Medicare program on which they depend.

Finally, I serve as Chairman of the Alliance for Home Health Quality and Innovation and serve on the Boards of Directors of the Community Health Accreditation Partner, the American Academy of Home Care Medicine, the Greater Newark Health Coalition, the New Jersey Hospital Association Health Research and Education Trust, and the Partnership for Quality Home Healthcare. I am proud to have also recently been elected to join the Board of Directors of the Visiting Nurse Associations of America.

Today's hearing is timely as every day, Medicare beneficiaries are being discharged from hospitals and are entering the post acute care (or "PAC") system. Each of us – policymaker and provider alike – share the hope that their journey will be a positive one and that these seniors will ...

- receive the care they need;
- understand – to the greatest extent possible – the path before them;
- be served in the most clinically appropriate and cost effective settings; and
- have their health and independence restored as quickly as is possible.

Unfortunately, the reality differs significantly from this vision. Too often, beneficiaries discharged hospitals experience uncoordinated and costly PAC care services. Instead of teamwork and clear care paths, there is often fragmentation and confusion. This lack of coordination can be dangerous for patients because important things about their care can be lost in their transition between care settings, and the stress and frustration can also take its toll on family caregivers who are often struggling to help their loved one while maintaining their own health. As a result, instead of efficiency, we see excessive costs being borne – by patients and the Medicare program.

I see this everyday. Like home health providers across the US, VNA Health Group serves many of the oldest and frailest beneficiaries in the Medicare program. According to an Avalere Health analysis of the Medicare Current Beneficiary Survey Access to Care File, home health patients are older, poorer, sicker and more likely to be female, minority and disabled than all other Medicare beneficiaries – combined:

| **Avalere Health – Home Health Beneficiary Study: Key Findings**[1] | **Medicare Home Health Beneficiaries** | All Other Medicare Beneficiaries |
|---|---|---|
| Women | **60.07%** | 53.9% |
| Beneficiaries aged 85+ | **24.4%** | 12.1% |
| Beneficiaries with 4+ chronic conditions | **74.7%** | 48.5% |
| Beneficiaries needing assistance with 2+ Activities of Daily Living (ADLs) | **23.5%** | 7.6% |
| Beneficiaries at or below 200% of Federal Poverty Level (FPL) | **66.2%** | 47.9% |
| Beneficiaries from ethnic or racial minority population | **19.3%** | 14.9% |
| Dual-eligible Medicare-Medicaid beneficiaries | **26.7%** | 17.7% |

As a result, we have seen firsthand how bewildering and burdensome the current "system" can be for Medicare beneficiaries and their families. Consider, for example, the story of a very typical beneficiary: Mrs. Smith is an 82-year-old woman with arthritis, congestive heart failure, and limited vision. She has

[1] http://homehealth4america.org/media-center/attach/207-1.pdf

just been discharged from the hospital where she had surgery to repair her broken hip. Mrs. Smith broke her hip when she tripped and fell in her home.

As Mrs. Smith nears the end of her stay in the hospital, she and her family aren't totally sure of what to do. She has a list of PAC providers in her area and has received some basic information, but everything is moving fast and she's still in pain from the surgery and sleepy from the pain medications. Her daughter, who is her main caregiver, isn't sure who is in charge of her care after she leaves the hospital. They're also not sure who to go to with questions.

In short, Mrs. Smith has several significant needs:

- She needs a holistic and comprehensive assessment of her post-hospital care needs that accounts for her medical, functional, and social/family circumstances. This assessment must lead to a patient-centered care plan that continues once she leaves the hospital, a plan that is well managed across the different post-acute providers and settings she may need.
- She needs help accessing that care in the best setting for her, as well as help to ensure her transition to that post acute care is as seamless as possible.
- She will need a range of support from registered nurses, physical and occupational therapists, social workers and physician care, ideally without the disruption and cost of ambulance transportation. She may also benefit from further evaluation of her low-vision, podiatry, and pharmaceutical needs.
- Finally, Mrs. Smith will need short-term assistance with such Activities of Daily Living as bathing and dressing while she recuperates and she may need help with nutrition (which is particularly important to seniors living alone). Depending on how well she recovers, Mrs. Smith and her family may need advice and referrals regarding long term care options.

Mrs. Smith's story isn't an atypical example. People like her are discharged from hundreds of hospitals across the country every day. They are our parents, our grandparents, our aunts and uncles and, soon, they may very well be us.

If Mrs. Smith and others like her receive the care they need, they will recuperate more quickly, at lower cost, and with a much lower risk of rehospitalization. But – too often today – they simply aren't receiving that well-coordinated care.

The reason is simple: today, too many Medicare beneficiaries like Mrs. Smith don't have the key ingredient: patient-centered care coordination.

The unfortunate reality is that, today, it's really no one's job to deliver patient-centered care coordination. No one is being paid to help Mrs. Smith with her transition from the hospital or to ensure she is able to get the right care at the right setting for her needs. Today, incentives are not aligned to get all people moving in the same direction and, as a result, patients are not being empowered or assisted, and care is not being coordinated.

If such care coordination were being consistently delivered, Medicare beneficiaries and their families would be far more likely to have what they need: a partner that's truly invested in helping them get better soon, a physician and nursing team to answer questions and monitor care, an integrated electronic health record that will help their providers have all the patient's medical information, and more.

We believe patient-centered care coordination can be achieved via PAC bundling that provides consistent support and navigation assistance to discharged Medicare beneficiaries. It's for this reason that the Partnership is pleased to add its support to the Bundling and Coordinating Post Acute Care (or "BACPAC") Act.

Under BACPAC, care coordination would begin on the day of a patient's discharge from the hospital and would continue as an episode of care for up to 90 days (unless the patient is admitted to the hospital for an unrelated condition). The BACPAC model would empower Coordinators to manage each episode. Coordinators would play an important role: they would establish provider networks consisting of licensed and accredited post-acute providers, coordinate patient care, reimburse providers within the bundle at amounts that cannot be less than those under current law, and manage the cost of the episode (either directly or via contract with third-party benefits managers or insurers). Just to become a coordinating entity, the potential candidate organizations will need to demonstrate a history of clinical and service excellence as well as competencies and capabilities, including in such critical arenas as care coordination, rehabilitation, and geriatric care.

In addition, BACPAC builds on the successful payment model for hospitals – the Diagnosis Related Group (or, "DRG") model, which has been used in hospitals for more than 30 years. Under BACPAC, Condition Related Groups (or, "CRGs") would work similarly to the way Medicare Severity DRGs do. Like DRGs, each CRG would serve as a "mini-bundle" that would account for substantially all of the care for each beneficiary. If treatment costs exceed a CRG's value or if the patient is rehospitalized for care related to their CRG condition, the Coordinator assumes full responsibility. By contrast, if costs are lower than the CRG's value, the Coordinator shares 100 percent of the savings with the discharging hospital, the

treating physician and the PAC providers who served the patient. In this way, CRGs would align incentives for improved outcomes and reduced cost.

Through its system of site-neutral CRG bundled payments and the responsibility that would be borne by Coordinators and their networks of providers and medical professionals, BACPAC would replace the artificial barriers that today impede collaboration. As MedPAC has noted, "Bundled payments ... encourage providers to coordinate care to focus on managing patient outcomes and controlling costs."[2]

Just as important, this reform measure ensures patient choice and network adequacy. Under BACPAC, patients and their families are able to choose their Coordinator as well as the providers within the Coordinator's network by whom they prefer to be treated. We anticipate that patients and their families will consult with their physician and make their choices based on the quality of the care that a Coordinator's affiliated network provides, the convenience of their locations, the technologies they deploy, the strength of their nursing corps, their partnerships with key community resources like YMCA and social services, and other key factors. All of this keeps patients at the center of their care and, unlike other concepts, ensures that patients are not limited to one set of providers based on their site of hospitalization or other factors.

Importantly, the Coordinator model may also do more than any other single reform to protect the integrity of the Medicare program because it is inconceivable that any Coordinator will select a bad actor for inclusion in its network. In order to be successful, Coordinators must contract with the highest quality and most efficient PAC providers. Furthermore, Coordinators must ensure that beneficiaries have

[2] http://www.medpac.gov/documents/20130614_WandM_Testimony_PAC.pdf, p 8.
[3] "Why Health Care Is Going Home" by Steven J. Landers, MD, MPH. *New England Journal of Medicine*. October 21, 2010.

access to the same comprehensive benefits and that post-acute providers are reimbursed in the same fashion as under current law. BACPAC is about adding care coordination and oversight with the goal of optimizing care – not taking away the rights or stature of patients or community providers. Providers who cannot deliver according to those standards – including those who engage in fraudulent or abusive behavior – will find they are completely locked out of Medicare's post acute care continuum.

Significantly, BACPAC would also foster greater use of clinical and technological innovations. Today, we are seeing a renaissance in the development of innovations that can improve patient care, outcomes, efficiency, and safety. As I wrote in the *New England Journal Medicine*, for example, physicians can now carry "a new version of the black bag that includes a mobile x-ray machine and a device that can perform more than 20 laboratory tests at the point of care."[3] And yet, antiquated Medicare regulations and payment rules compromise the ability of providers to utilize technologies. BACPAC would rectify this problem by enabling funds to be used for innovations that can improve outcomes and reduce cost.

Finally, BACPAC harnesses the efficiency it will achieve in the form of savings that will help sustain the Medicare program. Specifically, BACPAC is designed to reduce overall PAC spending by 4 percent over the next 10 years, which I understand has the potential to reduce Medicare costs by tens of billions of dollars. I should note, too, that none of these savings will come from Medicare beneficiaries, since BACPAC doesn't increase the burden of out-of-pocket costs, nor would they come from cutting provider reimbursement, because BACPAC protects providers' rates and payment structure at their current levels. Instead, savings are achieved through increased coordination and efficiency, thereby ensuring that patients get the care they need in the most appropriate and cost-effective settings while preventing unplanned, high-cost interventions such as ER visits and hospitalizations.

In short, BACPAC would build on the successful DRG precedent by creating a system of condition-specific CRGs that would strengthen care coordination, improve patient outcomes, ensure patient choice, and achieve significant savings. In contrast to the challenges which compromise post-acute care today, the BACPAC model would:

- Break down the barriers that today impair quality and produce inefficiency;
- Foster care coordination across today's siloes and among multiple providers;
- Enable care to be delivered in clinically appropriate and cost-effective settings;
- Permit investment in technologies and innovations that will lead to truly connected care;
- Align with Congress' passage of the IMPACT Act which created a unified PAC data tool; and,
- Achieve significant savings while rewarding physicians and providers for delivering quality care.

In closing, I would like to thank you again for convening this hearing and the privilege of participating in it. I also wish to express our appreciation and respect to the Committee and to Representatives David McKinley, Jerry McNerney, Tom Price and Anna Eshoo and their talented staff for their extraordinary work on and support for this complex but vitally-needed step forward. America's seniors deserve a Medicare program that provides high-quality preventive, therapeutic, rehabilitative and palliative care, and they want Medicare to be a program that will not burden their children and grandchildren with unsustainable costs.

We recognize that there are many complex issues that need to be worked through as you contemplate post acute care reform. My one request as you do so is to keep Mrs. Smith and seniors like her in mind. Their needs are real, and the current PAC system is not properly structured to meet them. As a result, the opportunity before you is not only to achieve real efficiency and improvement in Medicare post

acute care policy – it's to help ensure that Medicare post acute care policy works for the most vulnerable among us.

I know I speak for all my colleagues throughout the post acute care continuum when I express our gratitude for your dedication and service and extend an offer to assist you in any way we can.

Thank you.

**House Committee on Energy & Commerce – Subcommittee on Health**
**"Medicare Post Acute Care Delivery and Options to Improve It"**
Thursday, April 16, 2015 – 2322 Rayburn House Office Building

**Summary of Dr. Steven Landers Testimony**

- Today's hearing is timely and needed. Seniors discharged from hospitals are finding themselves in a poorly-coordinated and costly post-acute care continuum. Instead of order, there is disarray. Instead of teamwork and clear paths, there is fragmentation and confusion. And instead of efficiency, excessive costs are being borne by patients and taxpayers alike.
- VNA Health Group serves some of the oldest and frailest beneficiaries in the Medicare program. As a result, we have seen firsthand how bewildering and burdensome the current "system" is for ailing seniors and their families.
- Consider the example of Mrs. Smith:
  - Mrs. Smith is an 82-year-old woman with arthritis, congestive heart failure, and limited vision.
  - She is being discharged from the hospital where she was treated for a broken hip caused by a fall.
  - She has received some information but is still in pain and sleepy – she and her family aren't sure of what to do.
  - Her daughter, who is her main caregiver, isn't sure who is in charge post-discharge or who to go to with questions.
- Mrs. Smith has a number of basic – but important – needs, including:
  - a comprehensive and holistic assessment of her post-hospital needs and circumstances;
  - help accessing the care she needs in the setting that's right for her condition;
  - support from registered nurses, licensed therapists, social workers, and physicians; and,
  - short-term assistance with Activities of Daily Living and nutrition while she recuperates.
- Mrs. Smith's story isn't an atypical example. Patients like her are discharged from hundreds of hospitals every day. They are our parents, our grandparents, our aunts and uncles and, soon, they may be us.
- If Mrs. Smith and seniors like her receive the coordinated care they need, they will recuperate more quickly, at lower cost, and with a much lower risk of rehospitalization. But – too often today – they simply aren't receiving such care.
- Seniors like Mrs. Smith don't have what they need most: patient-centered care coordination.
  - Patient-centered care coordination means a partner that's truly invested in helping discharged patients get better soon, a physician and nursing team by their side every step of the way, an integrated electronic health record to avoid adverse events, and more.
- We believe patient-centered care coordination can be achieved via PAC bundling that adapts the successful DRG model and provides consistent coordination and navigation support to discharged beneficiaries and their families. It's for this reason that the Partnership is proud to add its support to the BACPAC Act.
- The BACPAC model incorporates elements that we feel are critical to patient-centered care coordination:
  - It is modeled on Diagnosis Related Groups (or "DRGs") which have been in use for over 30 years.
  - It creates DRG-like Condition Related Groups (or "CRG") to align interests and improve outcomes.
  - It ensures patient choice, network adequacy, and use of clinical and technological innovations.
  - It uses powerful risk and savings incentives to prioritize high-quality, consistently coordinated care.
  - It strengthens program integrity since no Coordinator will select a bad actor to be in its network.
  - It aligns with Congress' passage of the IMPACT Act, which created a unified PAC assessment tool.
  - And it achieves significant savings without cutting any provider or increasing costs for any senior.
- There are many complex issues to be addressed – as you do so, please keep seniors like Mrs. Smith in mind ... so that Medicare post acute care policy will not only be improved but will work for the most vulnerable among us.

Mr. PITTS. Dr. Hammerman, you are recognized for 5 minutes for your opening statement.

**STATEMENT OF DR. SAMUEL HAMMERMAN**

Dr. HAMMERMAN. Good afternoon. Thank you, Chairman Pitts and Ranking Member Green for holding today's hearing on the future of American post-acute care. My name is Dr. Samuel Hammerman. I am the chief medical officer of Select Medical's long-term acute care hospital division. I oversee more than 100 LTACH hospitals in 30 States.

I will try to offer some insights today based on my experiences and based on the experiences of the company I am proud to serve as the chief medical officer for, Select Medical. Select Medical is based outside Harrisburg, Pennsylvania, and is one of the largest providers of post-acute care in the country. Besides the 100-plus LTACH hospitals, Select Medical also operates about 20 inpatient rehabilitation hospitals, and 1,000 outpatient therapy clinics. All together, Select Medical employs over 30,000 Americans in more than 30 States.

Let me begin by saying that Select Medical does not oppose a bundled post-acute payment system. With this in mind, my observations on our post-acute care systems are as follows. I want to stress that Congress has already enacted extensive legislation laying the foundation for bundled payments for post-acute services. Just last fall, Congress passed the IMPACT Act of 2014. This law will enable Congress to develop an informed and evidence-based post-acute bundling system. We were happy to support this bipartisan bicameral bill.

The IMPACT Act will provide the Centers For Medicare and Medicaid Services and Congress with the necessary information, design a post-acute care payment system that stresses quality of care while maximizing efficiencies in the delivery of care. I salute Congress for moving to a new system while ensuring continued beneficiary access to the most appropriate setting of care.

On a similar note, I would note that the Affordable Care Act of 2010 established a number of new programs. It has post-acute bundling in hundreds of sites across the country. CMS is currently in the midst of numerous pilot programs testing numerous bundle payment concepts. In short, Congress and CMS have already largely commissioned a bundled future for post-acute care.

As a physician, I feel compelled to note that the current post-acute system still has many virtues. I would still make the case that the post-acute continuum of care represents a fairly logical and rational progression of care. Yes, we need to address the issue of readmissions, and yes, policymakers should always be concerned about whether care is appropriate and medically necessary.

As a historical aside, I ask you to consider that only about 10 percent of Medicare spending is devoted to post-acute care, and please recall how the post-acute sector came into being in the first place. In 1983, the Medicare program adopted the first prospective payment system which greatly encouraged hospitals to discharge patients more quickly.

Post-acute, as we know it today, only came into existence because of the incentives todischarge quickly from general hospitals. My ad-

vice to Congress is that you try to preserve a range of post-acute providers that offer a range of services from lower acuting nursing homes to higher acuity post-acute hospitals like rehabilitation hospitals and LTACH hospitals. All play a distinct role in meeting the needs of the American patient population.

One public policy issue important to both taxpayers and post-acute providers is ensuring that patients are cared for in the most appropriate setting. We agree that patients who can be safely and effectively cared for in sometimes less costly facilities like nursing homes should not be treated and paid for in rehabilitation hospitals and LTACH hospitals.

Little more than a year ago, Select Medical supported a new law passed by Congress designed to ensure that only appropriate patients are admitted to LTACH hospitals even though the law also significantly reduced Medicare reimbursement for these facilities. My larger point is that post-acute providers will continue to work with Congress to ensure that Medicare cost savings are achieved and beneficiary access to appropriate care is preserved.

Finally, I was asked to comment specifically on Congressman McKinley's BACPAC bill. BACPAC has some positive attributes, but it does not address many core elements of a bundled payment system and leaves these to the HHS Secretary to develop. Given the BACPAC's gaps, details on payment rates, a payment process, provider network requirements, a patient assessment process, and quality standards, the BACPAC bill appears to leave a great deal of policy work to CMS. This results in unanswered questions about how BACPAC would actually work in the real world. More importantly, we have concerns about the BACPAC bill because we feel it would shortcut the comprehensive payment reform processes that Congress launched in 2010 under the ACA and built upon in 2014 with the IMPACT Act.

Rather than supporting the IMPACT plan to first test bundling in the marketplace on a small scale, BACPAC would cut short this process. And given the complexity of the issues, this process is needed to develop a reliable and evidenced-based bundled payment program for post-acute care. Thank you.

Mr. PITTS. Thank you.

[The statement of Mr. Hammerman follows:]

**U.S. House Committee on Energy & Commerce**

Subcommittee on Health

Hearing: April 16, 2015

**Statement of Samuel Hammerman, M.D.**

*Chief Medical Officer, Long Term Acute Care Hospitals*

Select Medical Corporation

Good morning. Thank you, Chairman Pitts and Ranking Member Green for holding today's hearing on the future of American post-acute care. My name is Dr. Samuel Hammerman and I am the Chief Medical Officer of Select Medical's Long Term Acute Care ("LTAC") Hospital division. I oversee more than one hundred LTAC hospitals in thirty states.

Before joining Select Medical several years ago, I was director of pulmonary and critical care medicine for the northeast division of Geisinger Health System. Most of my twenty-plus years of practicing medicine have been in post-acute care.

In terms of Medicare policy, "post-acute" means inpatient rehabilitation hospitals, LTAC hospitals, home health and nursing homes. But, for me, personally as a physician, "post-acute" simply means how do we treat patients that are not well enough to go home immediately after a hospital stay.

I will try to offer some insights today based on my experiences and based on the experiences of the company I am proud to serve as a Chief Medical Officer for, Select Medical.

Select Medical is based outside Harrisburg, Pennsylvania and is one of the largest providers of post-acute care in the country. Besides the one hundred-plus LTAC hospitals, Select Medical also operates about twenty inpatient rehabilitation hospitals and a thousand outpatient therapy clinics. Altogether, Select Medical employs over 30,000 Americans in more than thirty states.

Before beginning with specifics, I want to note that Select Medical is proud to be a member of the American Hospital Association ("AHA"). I know the AHA has issued a statement as part of today's hearing and Select Medical agrees with the positions put forward by the AHA. I would refer you to the AHA and its policy statements for important insights into this debate.

Let me begin by saying that Select Medical does not oppose a bundled post-acute care payment system. With this in mind, my observations on our post-acute care system are as follows:

**POINT #1: Congress passed the IMPACT Act to address post-acute bundling.**

I want to stress that Congress has already enacted extensive legislation laying the foundation for bundled payments for post-acute services. Just last fall, Congress passed the "IMPACT" Act of 2014. This law will enable Congress to develop an informed and evidence-based post-acute bundling system. We were happy to support this bipartisan, bicameral bill.

**Statement of Samuel Hammerman, M.D.**
Representing Select Medical Corporation
Before the U.S. House Energy & Commerce Health Subcommittee
April 16, 2015

Congress noted in its own legislative history of the IMPACT Act that the law will enable Medicare to:

(1) Compare quality across post-acute settings;

(2) Improve hospital and post-acute coordination planning; and,

(3) Use this information to reform post-acute payments (via site neutral or bundled payments or some other reform).

The IMPACT Act will provide the Centers for Medicare and Medicaid Services ("CMS") and Congress with the necessary information to design a post-acute care payment system that stresses quality of care while maximizing efficiencies in the delivery of care. I salute Congress for moving to a new system -- while ensuring continued beneficiary access to the most appropriate setting of care.

**POINT #2: ACA also authorized a number of bundling demonstrations.**

On a similar note, I would note the Affordable Care Act ("ACA") of 2010 established a number of new programs to test post-acute bundling in hundreds of sites across the country. CMS is currently in the midst of numerous pilot programs, testing numerous bundled payment concepts. In short, Congress and CMS have already largely commissioned a "bundled" future for post-acute care.

**POINT #3: CMS may not be prepared to roll out bundling quicker than planned.**

I recognize there is a range of opinion on this Committee about the capacity of the Department of Health and Human Services ("HHS") and CMS. CMS appears, to some degree, overwhelmed right now with the magnitude of its duties related to the ACA and the repeal of SGR. I confess that – after watching the roll-out of the ACA – yes, I do worry about whether the agency has the resources at this time to immediately implement something as big as post-acute bundling.

**POINT #4: More experience is needed before we adopt comprehensive bundling.**

While Select Medical supports post-acute bundling in theory, we have been watching as the Medicare program has rolled out its bundling demonstrations. My impression is that these demonstrations have raised as many questions as answers.

For instance, many post-acute providers signed up for the initial stage of the demonstrations but only a small fraction of these providers proceeded to the next "at-risk" stage of the demonstrations. The initial results confirm the great complexity involved with designing, testing and refining new payment models to ensure that they work in the real world – before they are rolled out on a national basis.

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**POINT #5: Bundled payments may lead to unintended consequences.**

I ask you to also consider the possibility that rushing forward with any untested concepts of post-acute bundling may actually create new problems. For instance, as those of us who have lived through the evolution of managed care can attest, if not appropriately implemented and managed, a "bundled" payment provides incentives to reduce not only *unnecessary* care but also *necessary* care.

Establishing post-acute bundling without the necessary foundation creates a higher risk of unintended consequences that could adversely affect Medicare beneficiaries.

**POINT #6: Current system has some flaws but also has many virtues.**

As a physician, I feel compelled to note that the current post-acute system still has many virtues. I would still make the case that the post-acute continuum of care represents a fairly logical and rational progression of care. Yes, we need to address the issue of "readmissions" and yes, policy-makers should always be concerned about whether care is appropriate and medically necessary.

But all post-acute players – LTAC hospitals, rehabilitation hospitals, home health, and nursing homes – play a critical and distinct role in meeting the needs of the American patient population. Working together with each other, each provider category helps make a coherent whole of the post-acute continuum of care.

**POINT #7: "Post-acute" came into existence after policy to discourage hospital stays.**

As a historical aside, I ask you to consider that only about ten percent of Medicare spending is devoted to post-acute care. And please recall how the post-acute sector came into being in the first place: In 1983, the Medicare program adopted the first "prospective payment system" which greatly encouraged hospitals to discharge patients more quickly.

As the average patient stay in hospitals dropped from three weeks to five days, post-acute care facilities filled the gap left by the new system. Post-acute as we know it today only came into existence because of the incentives to discharge quickly from general hospitals.

My advice to Congress is that you try to preserve a range of post-acute providers that offer a range of services, from lower-acuity nursing homes to higher-acuity post-acute hospitals like rehabilitation hospitals and LTAC hospitals.

**POINT #8: Post-acute providers are addressing public policy issues.**

One public policy issue important to both taxpayers and post-acute providers is ensuring that patients are cared for in the most appropriate setting. We agree that patients who can be safely and effectively cared for in sometimes less-costly facilities – like nursing homes -- should not be treated and paid for in rehabilitation hospitals and LTAC hospitals.

Little more than a year ago, Select Medical supported a new law passed by Congress designed to ensure that only appropriate patients are admitted to LTAC hospitals even though the law also significantly reduced Medicare reimbursement for these facilities.

Treating patients in the most appropriate setting is not only right for our seniors, but also creates savings for the Medicare program. My larger point is that post-acute providers will continue to work with Congress to ensure that Medicare cost savings are achieved and beneficiary access to appropriate care is preserved.

**POINT #9: BACPAC short-circuits IMPACT and ACA processes.**

Finally, I was asked to comment specifically on Congressman McKinley's "BACPAC" bill. BACPAC has some positive attributes but it does not address many core elements of a bundled payment system – and leaves these to the HHS Secretary to develop.

Given BACPAC's gaps – *e.g.*, details on payments rates, a payment process, provider network requirements, a patient assessment process, and quality standards – the BACPAC bill appears to leave a great deal of policy work to CMS. This results in unanswered questions about how BACPAC would actually work in the real world.

More importantly, we have concerns about the BACPAC bill because we feel it would shortcut the comprehensive payment reform processes that Congress launched in 2010 under the ACA and built upon in 2014 with the IMPACT Act.

Rather than supporting the IMPACT plan -- to first test bundling in the marketplace on a small scale -- BACPAC would cut short this process. And, given the complexity of the issues, this process is needed to develop a reliable and evidence-based bundled payment program for post-acute care.

Mr. PITTS. Dr. Morley, you are recognized for 5 minutes for opening statement.

**STATEMENT OF MELISSA MORLEY, PH.D**

Ms. MORLEY. Chairman Pitts, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to speak with you today. Since 2007, I have worked on several projects with the assistant secretary for planning and evaluation and CMS looking at both the composition of PAC episodes and the potential to predict episode spending using patient assessment data. On the basis of my experience conducting research in this area, I will highlight several relevant findings and note data and analysis required to move this payment approach forward.

The proportions of Medicare beneficiaries discharged to PAC, episode utilization and spending differs significantly across the United States because of varying practice patterns and availability of PAC providers. Differences in provider supply, particularly with regard to long-term care hospitals, LTACHs, and inpatient rehabilitation facilities are key drivers of differences in overall episode spending.

Establishing an episode-based payment requires an understanding of service use and spending on average; however, this is challenging when considering high cost but low-frequency services such as LTCH. For example, although only 2 percent of beneficiaries discharged to PAC use LTCH services, the mean cost for those using LTCH is over $35,000. When this spending is averaged over all PAC users, the mean cost is less than $700. This demonstrates a challenge in establishing a payment rate that is sufficient to accommodate the range of PAC services.

To build a payment system for PAC episodes that is risk adjusted based on patient characteristics, standardized patient assessment data are critical. However, standardized assessment data are not currently collected across PAC settings. As part of exploratory work with ASPE, we have examined the potential to develop risk adjustment models using items from the CARE data collected as part of the post-acute care payment reform demonstration.

These efforts have demonstrated the potential to use CARE items as risk adjustors to predict episode spending. Results of this work also highlight important differences in the predictive power of the models, depending on the first site of PAC. This foundational work is valuable in demonstrating the potential to use CARE items in an episode-based payment system, but additional data are needed to test the models on larger samples and to examine any differences in significant risk adjustors across diagnosis groups.

With the passage of the IMPACT Act, more data may become available over the next several years, although it is not clear at this time which items will be collected across PAC settings and whether the data that will be collected will be sufficient for the purposes of building an episode-based payment system.

Addressing the complexities of an episode-based payment system will require additional analyses as well as consideration of the results of the evaluation of the CMS Bundled Payments for Care Improvement initiative. The BPCI initiative is currently testing whether a bundled payment can reduce cost while maintaining or improving quality of care for Medicare beneficiaries.

The first evaluation report is an early assessment based on one quarter of data; however, results of analyses looking at cost shifting to the post-bundle period, beneficiary outcomes, using assessment data, and beneficiary experience using surveys are expected in future reports. Evaluation results comparing PAC service-only episodes with more integrated episodes that include both the acute hospitalization and PAC services will also provide valuable information on provider incentives across episode definitions.

The foundation of an episode-based payment system is the diagnosis groups on which payments are made. Significant analyses and input from clinicians will be needed to develop the categories of diagnoses and to define unrelated readmissions. Analyses to develop payment adjustments for geography will be important to address differences in provider supply and in cost of care across geographic areas. Consideration of provider networks and resources to support beneficiary choice will also be important.

Another consideration is related to the establishment of payments for services that continue past the end of an episode period. End-of-episode patient assessment data could not only support any post-episode service payment but also could be valuable information for ensuring quality of care. Episode-based payments offer the opportunity to coordinate across settings to provide care more efficiently and with greater beneficiary focus. The results of the ongoing analyses in the BPCI evaluation as well as availability of national standardized patient assessment data will be very important to moving this payment design forward.

Thank you for the opportunity to speak with you today.

Mr. PITTS. Thank you very much for your testimony.

[The statement of Ms. Morley follows:]

# Medicare Post-Acute Care Delivery and Options to Improve It

## Testimony before the U.S. House of Representatives

## Energy and Commerce Committee

## Subcommittee on Health

**Statement of**

**Melissa A. Morley, Ph.D.**
**Program Manager, Health Care Financing and Payment Program**
**RTI International**

**April 16, 2015**

Good morning, Chairman Pitts, Ranking Member Green, and members of the Subcommittee. Thank you for the opportunity to speak with you today regarding the development of a payment system for episodes of post-acute care (PAC).

My name is Melissa Morley, and I am a researcher in the Health Care Financing and Payment Program at RTI International. RTI is an independent, nonprofit institute that provides research, development, and technical services to government and commercial clients worldwide. I am a graduate of Tufts University; McMaster University, where I studied health economics and Canadian health policy as a Fulbright Scholar; and the doctoral program at the Heller School for Social Policy and Management at Brandeis University. Since 2007, I have worked on several projects with the Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy and the Centers for Medicare & Medicaid Services (CMS), looking at both the composition of PAC episodes and the potential to predict episode spending using patient assessment data. On the basis of my experiences conducting research in this area, I will highlight several relevant findings and note data and analyses required to move this payment approach forward.

## Understanding PAC Episodes and Variation across the United States

The proportions of Medicare beneficiaries discharged to PAC, episode utilization, and spending differ significantly across the United States because of varying practice patterns and availability of PAC providers. Exhibit 1 shows these differences across 10 states that are among the top 5, middle 10, and bottom 5 by mean episode spending per beneficiary discharged to PAC. For example, 50.5% of beneficiaries are discharged to PAC services in Massachusetts, compared with 31.9% in Montana (Morley, Bogasky, Gage, Flood, & Ingber, 2014). Differences in provider supply, particularly with regard to long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), are key drivers of differences in overall episode spending. Home health agencies (HHAs) and skilled nursing facilities (SNFs) are generally available across geographic areas.

Establishing an episode-based payment requires an understanding of service use and spending on average. However, this is challenging when considering high-cost but low-frequency services such as LTCH and IRF services. Exhibit 2 demonstrates this issue by showing the differences in the mean spending per beneficiary using a particular service compared with the mean spending per beneficiary discharged to PAC (regardless of whether a particular service is used). For example, although only 2 percent of beneficiaries discharged to PAC use LTCH services, the mean cost for those using LTCH is over $35,000. When this spending is averaged over all PAC users, the mean cost is less than $700. This difference demonstrates a challenge in establishing a payment rate that is sufficient to accommodate the range of PAC services, especially given the differences in the supply of providers across the country.

## Data Required for Episode-Based Payment System Development

To build a payment system for PAC episodes that is risk adjusted based on patient characteristics, standardized patient assessment data are critical. However, standardized assessment data are not currently collected across PAC settings. As part of exploratory work with ASPE, we have examined the potential to develop risk adjustment models using items from the Continuity Assessment Record and Evaluation (CARE) data, collected as part of the Post-Acute Care Payment Reform Demonstration (PAC-PRD) from 2008 through 2010, as well as items from the currently mandated assessment instruments (Morley et al., 2013; Morley, Coomer, Ingber, Deutsch, & Briggs, 2015). These efforts have demonstrated the potential to use CARE items (including medical items and items related to motor functional and cognitive status) as risk adjustors to predict episode spending. Results of this work also highlight important differences in the predictive power of the models, depending on the first site of PAC after discharge from an acute hospitalization. This foundational work is valuable in demonstrating the potential to use CARE items in an episode-based payment system, but additional standardized patient assessment data are needed to test the models on larger

samples and to examine any differences in significant risk adjustors across diagnosis groups (such as neurologic, cardiovascular, orthopedic, and so on). With the passage of the Improving Medicare Post-Acute Care Transformation Act of 2014—the IMPACT Act—more data may become available over the next several years, although it is not clear at this time which items will be collected across PAC settings and whether the data that will be collected will be sufficient for the purposes of building an episode-based payment system.

## Additional Considerations: Complexities of Episode-Based Payments

Addressing the complexities of an episode-based payment system will require additional analyses as well as consideration of the results of the evaluation of the CMS Bundled Payments for Care Improvement (BPCI) Initiative. The BPCI Initiative is currently testing whether a bundled payment can reduce costs while maintaining or improving quality of care for Medicare beneficiaries (Dummit et al., 2015). Evaluation results to date on Model 3, which defines an episode as including PAC service use only, are limited in that there only nine episode initiators, seven of which are skilled nursing facilities. The first evaluation report is an early assessment of the BPCI Initiative based on one quarter of data. However, results of analyses looking at cost-shifting to the post-bundle period; beneficiary outcomes, using assessment data; and beneficiary experience, using surveys, are expected in future evaluation reports. Evaluation results comparing PAC-service-only episodes (Model 3) with more integrated episodes that include both the acute hospitalization and PAC services (Model 2) will also provide valuable information on provider incentives across episode definitions, as well as on differences in overall episode utilization and spending, cost-shifting, and beneficiary outcomes.

The foundation of an episode-based payment system is the diagnosis groups on which payments are made. Significant analyses and input from clinicians will be needed to develop the categories of diagnoses and to define unrelated readmissions for all diagnosis groups. Analyses to develop payment adjustments for geography will be important to

address differences in provider supply and differences in costs of care across geographic areas to ensure that payments are sufficient to provide care. Consideration of provider networks and resources to support beneficiary choice will also be important. For example, networks will need to accommodate care for beneficiaries in rural areas that may be far from where a beneficiary has his or her index acute hospitalization. Another consideration is related to the establishment of payments for services that continue past the end of an episode period. If an episode-based payment is made prospectively, as is the case across the current PAC payment systems, establishing a payment for services falling after the episode window will be important to consider. If establishing payment for post-episode services requires patient assessment data, there are implications for the timing of assessment data collection. End-of-episode patient assessment data could not only support any post-episode service payment but also could be valuable information for ensuring quality of care in episodes.

Episode-based payments offer the opportunity to coordinate across settings to provide care more efficiently and with greater beneficiary focus. The results of the ongoing analyses in the BPCI evaluation as well as availability of national standardized patient assessment data will be very important to moving this payment design forward. Thank you for the opportunity to speak with you today.

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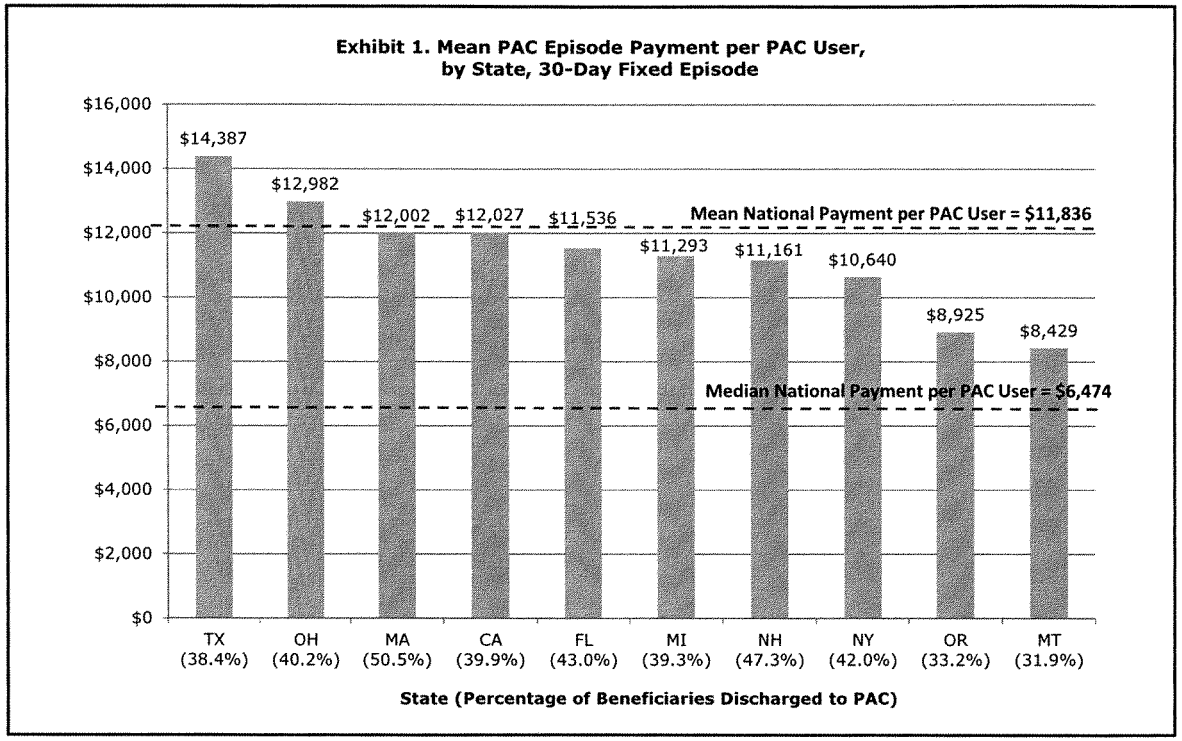


NOTES:

1. Adapted from Exhibit 5 from Morley, M., Bogasky, S., Gage, B., Flood, S., & Ingber, M. (2014). Medicare post-acute care episodes and payment bundling. *Medicare & Medicaid Research Review, 4*(1), E1–E12. doi:10.5600/mmrr.004.01.b02. 2. The 30-day fixed-length episode includes all long-term care hospital (LTCH), inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), home health agency (HHA), and therapy claims initiating within 30 days of acute hospital discharge. 3. PAC, post-acute care.

**Exhibit 2. Mean PAC Episode Payments, By PAC Service, 2008**

| Episode Definition | 30-Day Fixed Length Episode |
|---|---|
| Home health agency (HHA) | |
| Percentage with claim | 52.2 |
| Mean payment per service user | $2,786 |
| Mean payment per PAC user | $1,455 |
| Skilled nursing facility (SNF) | |
| Percentage with claim | 45.3 |
| Mean payment per service user | $11,476 |
| Mean payment per PAC user | $5,204 |
| Inpatient rehabilitation facility (IRF) | |
| Percentage with claim | 9.0 |
| Mean payment per service user | $16,504 |
| Mean payment per PAC user | $1,489 |
| Long-term care hospital (LTCH) | |
| Percentage with claim | 2.0 |
| Mean payment per service user | $35,203 |
| Mean payment per PAC user | $691 |
| Acute hospital readmission | |
| Percentage with claim | 14.8 |
| Mean payment per service user | $11,594 |
| Mean payment per PAC user | $1,718 |

NOTES:

1. Adapted from Exhibit 4 from Morley, M., Bogasky, S., Gage, B., Flood, S., & Ingber, M. (2014). Medicare post-acute care episodes and payment bundling. *Medicare & Medicaid Research Review, 4*(1), E1–E12. doi:10.5600/mmrr.004.01.b02.
2. The 30-day fixed-length episode includes all long-term care hospital (LTCH), inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), home health agency (HHA), and therapy claims initiating within 30 days of acute hospital discharge.
3. PAC, post-acute care.

Mr. PITTS. Mr. Russ, you are recognized 5 minutes for your opening statement.

**STATEMENT OF LEONARD RUSS**

Mr. RUSS. Well, thank you, Chairman Pitts, and thank you, Ranking Member Green, and members of the committee. I will be speaking somewhat extemporaneously and divert somewhat from my prepared remarks only because I think the testimony as written is in the record.

I would like to say at the outset, I am Len Russ, I am current chairman of the American Health Care Association. We represent nearly 13,000 skilled nursing facilities around the country, serving more than 2 million Medicare beneficiaries each year for short-term stays.

At the same time, our members are also hybrids. We also deal with the long-term population. We are also serving Medicaid patients, and I think, alluding to what was the earlier testimony today, that margin that we constantly focus on, we have to look at the real margins because we are taking care of a hybrid kind of population, all of which fall under the umbrella of our Nation's frail and elderly.

We, as skilled nursing facilities under the Medicare system, are one of the remaining sectors that still are paid basically on a fee-for-service system. The fee-for-service model that we currently enjoy is the prospective payment system. The prospective payment system has been in existence now for the better part of more than a decade, and has been subject to many criticisms, tinkering by CMS, et cetera, for the fact that there has been concern that there was an over-delivery of certain services at the expense of the under-delivery of others.

We at HCA champion the notion of healthcare reform. We believe in payment reform, and we have come up with a proposal ourselves to change payment reform for our sector as possibly a building block towards bundling. We do not believe that this current iteration of bundling is workable. We don't believe that the opening up of the conveners or third-party managers of a bundle will do anything to manage care but more likely just manage payment.

And as we have heard throughout the day, we talked about the, you know, breaking down silos, I think we need to be very mindful that by simply breaking down a payment cycle doesn't necessarily break down the care delivery system. That coordination is not always in line with simply realigning the payment system.

So having said that, we at HCA have come up with basically six principles by which we think any bundling proposal or largely any healthcare reform proposal needs to adhere to. The first is that with any post-acute care sector, the management of that bundle really should be left with the providers in the post-acute care space. So that hospitals, which the BACPAC bill would still allow to be the sort of care coordinator or third-party conveners, which might siphon off precious dollars from the payment into their own pocket, so to speak, for allegedly managing the care, whereas they are just managing the dollars, is probably not productive.

We also believe that smaller providers, and our organization represents very large corporations as well as regional companies, inde-

pendent owners like myself do not have the economic muscle to be able to take on the kind of risk that would be required in order to become a care coordinator. So this is not going to present us with a level playing field.

Secondly, we want to be sure that Medicare beneficiaries have provider choice, and we see that the possibility that these kinds of bundles could raise barriers rather than break down barriers to access care. I also, for example, have five-star facilities, but I am not allowed to join certain networks in managed care right now because they don't necessarily need the access, and there are facilities that are perhaps one-star facilities who are in the network. So the notion that the quality facilities will rise to the top has so far not been borne out.

So we are not able to possibly join some of the these networks and offer the members choice, and I think any qualified excellent quality provider should be able to have access. We want additional flexibility in rendering care, not with a relaxation of regulations but being less prescriptive with how many minutes of therapy we give, with the venue of the therapy, so that we are measured on quality and outcomes.

AHCA has worked collaboratively with CMS and our partners on the Hill to make monumental strides in terms of improving quality over the last several years, both in terms of rehospitalization rates, in terms of reduction of antipsychotic medications, et cetera.

Finally, I just want to say that in any bundled system, we need a virtual bundle, not an actual bundle. A virtual bundle is something where the providers, even if they are aligned in a cohesive spectrum of care, can bill Medicare directly as opposed to leaving it to one provider to hold the dollars and have the others go to that provider to get paid. It is not necessarily a reliable payment system and it is not necessarily something that can be held accountable in the very, very thin margins and the cash flow stresses in which we operate. So with that, I will——

Mr. PITTS. The chair thanks the gentleman.

[The statement of Mr. Russ follows:]

Testimony of Leonard Russ
Chair, Board of Governors
American Health Care Association

House Energy and Commerce Health Subcommittee
"Medicare Post-Acute Care Delivery and Options to Improve It"

April 16, 2015

**Executive Summary**

- I am Len Russ, the Chair of the American Health Care Association (AHCA).
- Skilled nursing centers provide rehabilitative care to more than 2 million Medicare beneficiaries each year. In 2013 the federal government spent $32 billion on skilled nursing center care, representing 49% of all PAC spending. We differ from other PAC providers in many ways primarily hinging both upon on the long-term relationships we build with the people and families we serve and the complex nature of the skilled nursing center care.
- AHCA recognizes the need to modernize PAC payment systems. The Association supported both the Improving Post-Acute Care Transformation (IMPACT) Act of 2014, the Protecting Access to Medicare Act (PAMA), which included a SNF-specific hospital readmission program.
- Additionally, AHCA has a forward thinking payment reform concept under development, now, which we believe valuable to the unfolding PAC reform dialogue framed by the IMPACT Act.
- The road to PAC reform includes many possibilities including bundling. And, AHCA is interested in bundling as a reform option. To that end, AHCA has six bundling principles which we believe should be met by any bundling proposal. Unfortunately, BACPAC does not meet these principles, therefore, we oppose the measure.
- On a national level, the outcomes of care provided in skilled nursing care centers are steadily improving. The Association and its members have, will continue to make, significant investments aimed at improving quality via our Quality Initiative.

**Introduction**

Good Morning, Chairman Pitts, Ranking Member Green, and distinguished members of the Committee. I'd like to thank you for holding this hearing to examine options to improve the delivery of post-acute care (PAC), and I especially appreciate the opportunity to appear before you here today. My name is Leonard Russ, and I am the Chairman of the American Health Care Association (AHCA) and the Principal Partner of Bayberry Health Care, New York based partnership specializing in skilled nursing, sub-acute and in-patient rehabilitative care. I am also co-owner of Aaron Manor Nursing & Rehabilitation Center outside Rochester, New York. My facilities have consistently earned four and five star ratings by CMS and have repeatedly been ranked among the Best Nursing Homes in America by US News and World Report. AHCA is the nation's largest association of long term and post-acute care providers with more than 12,000-plus members who provide care to approximately 1.7 million residents and patients every year. Members include not-for-profit and proprietary skilled nursing facilities, assisted living communities, and residences for persons with developmental disabilities. AHCA and the skilled nursing professionals we represent look forward to continuing our work with policymakers to advance long-needed PAC delivery and payment reforms. We are excited to be able to share our views with you today and outline what we believe are rational, achievable steps on that road to true PAC reform.

**Background on Skilled Nursing**

Skilled nursing centers provide rehabilitative care to more than 2 million Medicare beneficiaries each year. In 2013 the federal government spent approximately $30 billion on Medicare-financed

skilled nursing center care, representing 49% of all Medicare PAC spending. We differ from other PAC providers in many ways. First, because we are a hybrid of short-term rehabilitation facilities and long-term care facilities, we tend to experience a certain amount of cross-over between the two populations. Stated more plainly, rather than delivering only short-stay rehabilitation services, people also reside in our centers where they receive long term services and supports. Second, we develop relationships with our short-term rehab patients many of whom eventually become our long-term residents. And, as such, we deliver supports and related care management to long-term residents over several years. Third, such experience allows us to deliver care management to both short-stay PAC patients, long-stay residents, as well as when long-stay residents require PAC services following an acute care episode.

In terms of care, when an individual is admitted to a skilled nursing center for rehabilitation, we are held accountable to caring for all of health care needs, even if their full array of care needs are unrelated to the reason for the preceding hospitalization. Data clearly show that patients of skilled nursing centers have more complex and comorbid conditions, such as dementia, compared with the general Medicare population that receives post-acute care services. Because skilled nursing providers are unique in this regard, policy makers should be thoughtful when attempting to make broad comparisons between provider types. We believe PAC reform efforts in today's health care environment are much more likely to succeed if they recognize the nature of SNF patient and resident characteristics and service delivery which differentiate us from other PAC providers.

Regarding payment, AHCA recognizes the need modernize our existing Medicare prospective payment system (PPS). Of note, skilled nursing centers are the only PAC provider type paid

using a per diem system rather than a single payment for an entire PAC stay or episode of care. We agree, and I will discuss later, our preliminary ideas on modernization of our payment system.

For now, I think it important to understand that the goal of many of the payment and delivery system reform efforts is to create incentives for providers to take a more active role in care management and coordination activities. As such models are considered, policy makers should rely upon the knowledge and experience of the skilled nursing profession, such as our care management expertise discussed above, in the design of new payment systems, such as bundled payments and ACOs. We believe leveraging SNF expertise in this area is more effective for patients and residents and more efficient for the Medicare program than introducing third party payers which could consume valuable resources which could be used to improve patient or resident services.

In terms of Congressional action to modernize Medicare-financed PAC services, the Improving Post-Acute Care Transformation (IMPACT) Act of 2014 will finally allow for the collection of equivalent assessment data across PAC provider types and directs MedPAC and the Centers for Medicare and Medicaid Services (CMS) to study and develop an array of quality measures as well a vision for PAC payment reform. CMS IMPACT Act-related efforts likely will rely heavily on the Deficit Reduction Act-mandated PAC Payment Reform Demonstration. AHCA strongly supported the IMPACT Act, as well as the Protecting Access to Medicare Act (PAMA), which included a SNF-specific hospital readmission program. We believe the IMPACT Act contains a thoughtful, staged timeline for PAC reform.

**Quality Improvements in America's Skilled Nursing Centers**

On a national level, the outcomes of care provided in skilled nursing care centers are steadily improving. In recent years, there have been across-the-board improvements in virtually all quality measures generally used in this field. The proportion of centers receiving the highest rating (i.e., five stars) on the CMS Five-Star Quality Rating System scale increased from 13 percent in 2009 to 28 percent in 2014. Starting in February of this year, CMS arbitrarily rebased scoring for the Five-Star Quality Rating System resulting in an abrupt change in the proportion of centers at each star level, thus, we are not able to compare trends prior to 2015 with current and future time periods.

In early 2012, the Association launched the Quality Initiative, a member-wide challenge to meet specific, measurable targets in four distinct areas: hospital readmissions, staff stability, customer satisfaction and the off-label use of antipsychotic medications. Since the launch of the initiative, members have demonstrated meaningful improvements in quality care for the two goals that we are able to measure using national data sets: hospital readmission and antipsychotic use. AHCA members have reduced hospital readmissions by 14.2 percent (18.3 percent in 2011 to 15.7 percent in 2014). In that same time period, member centers reduced the off-label use of antipsychotic medications by 21.1 percent (23.7 percent in 2011 to 18.7 percent in 2014). National data on turnover and satisfaction is not yet available to adequately evaluate these two goals.

AHCA continues to lead the field and support our members with regard to a focus on systematic improvement and high quality performance. The next phase of our quality initiative, with future

targets and strategies reflective of national priorities outlined in the IMPACT Act and other congressional and administrative efforts to align quality with payment and regulatory policy, will be announced in the coming month.

The AHCA/NCAL National Quality Award Program is a progressive, three-step program based on the nationally recognized Baldrige Performance Excellence criteria. Members can apply for recognition at the Bronze, Silver and Gold levels, each requiring more detailed and comprehensive demonstration of systematic quality performance and organizational effectiveness.

The program is a member of the Alliance for Performance Excellence, an association of the 33 recognized Baldrige-based award programs in the nation. The AHCA/NCAL program is the largest of these programs, with a volume of applications that exceeds the combined total of all the other 32 programs and the National Baldrige program. From 2010–2013, the state and national Baldrige programs received a total of 691 applications; whereas, in the same timeframe, the AHCA/NCAL Quality Award Program received 3,946 applications. As of the 2014 award cycle, 2,988 members have achieved the Bronze Award, 365 members have achieved the Silver Award, and 24 members have achieved the Gold Award. Research demonstrates that AHCA/NCAL Gold and Silver Quality Award recipients consistently outperform other centers on objective quality metrics, readmissions and antipsychotic use.

**The (Limited) Skilled Nursing Center Experience with Bundled Payments**

AHCA believes implementing true bundled PAC payments will, and should, take several years to test and implement, if done properly. While limited, we do have some experiential evidence from which to draw some preliminary conclusions. The CMS Bundled Payments for Care Improvement (BPCI) initiative, which seeks to test several models of bundled payments across a range of providers, is only now just getting off the ground. Unfortunately, but unsurprisingly, early results are inconclusive, and they raise more questions than answers.

Through regular engagement with AHCA members who are participating in the BPCI initiative at varying stages, we have uncovered a host of operational challenges, as well as policy design flaws, that lead us to believe that truly scalable bundled payments may still be many years out. For example:

- Current information technology systems and reporting processes do not allow PAC providers to correctly identify patients by the complicated assignment and precedence rules included in the BPCI program. Without being able to identify which patients are bundled payment patients up front, providers are unable to appropriately target those patients with individualized care protocols necessary under a bundled payment model. Anecdotal evidence suggests that skilled nursing providers may be mis-identifying up to 30 percent of patients.
- We have many questions and concerns regarding the role of the non-provider conveners in BPCI. Based on our experience, the role of these conveners is not completely clear to provider participants, or to the industry overall, particularly when the convener is a third-party entity that does not have direct ownership, governance, or management accountability to a provider under the Medicare program. Agreement between third-party

conveners and SNF providers often include shared accountability, a financial relationship and specific programs and services that SNFs receive as part of partnering with a convener. The implications and viability of these relationships are currently not fully clear and largely untested.

- Because the savings requirement under BPCI is directly tracked and attributable at the MS-DRG and clinical condition level by participating SNF, in order for participants to be successful under the program, there must be enough volume within the facility and within the clinical condition to be able to spread actuarial and financial risk and overcome inherent, uncontrollable outliers. While BPCI includes some outlier relief via their risk track options, these risk tracks do not fully mitigate financial risk for participants when outliers occur and on a low volume of cases these outlier impacts are magnified. Most SNFs do not treat a significant volume of patients within each clinical condition during a calendar year, exposing them to these outlier risks and impacts on low volume conditions. This actuarial risk further disadvantages smaller providers, particularly in rural markets.

These represent only a few select examples of the challenges our members are facing under bundled payments. Given what we know so far, and the host of challenges we have been able to identify, we strongly believe a comprehensive bundling approach is premature without more complete results from demonstration efforts, such as BPCI.

**The BACPAC Act and AHCA's Approach to Evaluating Bundled Payment Proposals**

What we have been able to glean from our members by their participation in BPCI has allowed us to better understand what must, and what must not, be included in any viable bundled

payment legislative proposal. As a result, AHCA has adopted a set of six guiding principles against which to evaluate PAC bundled payment models:

1. **The policy must place the management of the episode with post-acute care providers.** We believe strongly that providers are the most appropriate and capable entities to manage the care of patients within a post-acute episode, and that inserting a third-party entity between the payer, patients and the provider would create strong incentives to siphon away valuable resources that could otherwise be used in direct patient care.
2. **The policy must preserve a patient's freedom of choice of provider.** Freedom of choice is a foundational element of the Original Medicare program and should not be limited by attempts to reform payment systems.
3. **The policy must allow providers the flexibility to deliver patient-centered care in order to achieve the patient's highest practicable level of function and outcome.** We believe the existing regulatory framework should be nimble enough to allow for more patient-centered care in an environment where providers are assuming financial risk, and where incentives are aligned to meet the patient's quality of care and quality of life needs.
4. **The policy must establish episodes that bundle PAC services only and do not include the immediately preceding acute care hospitalization.** There is strong evidence demonstrating that the acute care delivered to patient does not directly correlate to, nor can it predict, the costs and patterns of the post-acute care that subsequently will be needed. Therefore, trying to develop episodes that encompass both acute and post-acute services is difficult, if not impossible, to do accurately.

5. **The policy must establish "virtual" bundles as opposed to "actual" bundles.** Because the typical marketplace is not organized in a way that allows the typical PAC provider to accept a bundled payment, and to then make payments to other providers, we do not believe prospective bundles could be implemented nationally.
6. **The policy must not inadvertently create access barriers for patients with complex or chronic diseases.** Policies that lack comprehensive, PAC-specific risk-adjustment methodologies, which account for clinical severity and complexity, would create perverse incentives for providers to avoid sicker, more costly patients.

Additionally, we also believe savings should come from more efficient delivery of services and care coordination rather than just from shifting the site of care. When we evaluate the BACPAC Act against our six principles, the measure either directly fails to meet the principle or lacks enough clarity for us to make a determination. Indeed, the lack of clarity in the BACPAC Act is, in our opinion, one of its greatest weaknesses. We believe that there are other paths which policy makers could be explored which would advance PAC reform without creating an unnecessary level of turmoil among providers who must be successful in implementing these reforms and beneficiaries.

**AHCA's Approach to PAC Payment Reform**

The Association also wants to be an active participant in PAC payment reform efforts. Last year as Chair of the AHCA Board, I initiated an AHCA/NCAL Payment Reform Initiative. The goal of the effort is to develop a viable, proactive ad comprehensive vision for payment reform. As we approached designing our preliminary concept, the membership focused on four criteria: 1) improve quality and patient outcomes; 2) offer savings to the federal governmental; 3) ensure the

concept may be operationalized by CMS; and 4) offer a viable payment system for all AHCA members.

After considerable member discussion, we crafted a SNF-only episode. Stated another way, we would replace the current per diem payment system and replace it with a single SNF-only episode payment which would cover all SNF Part A services from admission to discharge. Base rates would be based on patient characteristic defined condition categories and would be risk adjusted using an assessment tool. The adjusted rates then would be discounted by some percentage to achieve federal savings. As part of our proposal, we also would partially eliminate the archaic three-day stay. In our proposal, we have included a policy to allow one and two day inpatient hospital short stay patients access to SNF services.

While we still are conducting in depth modeling at the member and SNF market levels, we believe the concept would lay the foundation for out-year IMPACT Act payment reform by moving the SNF profession away from a per diem system to a stay of care or episode of care system there by aligning us with other PAC providers. The concept also would allow SNF providers and CMS to gain experience with a SNF-only stay-based payment as work is conducted on the IMPACT Act vision for a unified, cross-PAC setting payment system based on patient characteristics.

**Conclusion**

Due to the rehabilitative, rather than curative nature of PAC services, defining services and related payment is particularly difficult. Prior year work, such as the Deficit Reduction Act PAC Payment Reform Demonstration (PAC-PRD) findings, including the CARE Tool, will be

important to IMPACT Act and any other PAC reform efforts. Additionally, development of the PAMA SNF rehospitalization program and related IMPACT Act reporting measures will need to be harmonized with similar efforts underway for hospitals and physicians. AHCA stands ready to work with Congress, members of this and other Committees, as well as other health care providers on a road to PAC payment reform which will improve quality and outcomes for patients and their families.

Mr. PITTS. I thank all the witnesses for your testimony. I will begin the questioning and recognize myself 5 minutes for that purpose.

Dr. Morley, you state in your testimony that there are geographic differences in the number of beneficiaries discharged post-acute care. Is this exclusively a provider distribution issue or is it a result of regional variation in standards of care?

Ms. MORLEY. I think it is both. Provider distribution is most clear, particularly using the example of the LTCHs or areas of the country without any access to LTCH providers, and that care is primarily delivered in acute care hospitals and skilled nursing facilities. However, there are also geographic differences in just patterns of care, so it is both factors that are contributing to the variation.

Mr. PITTS. You state in your written testimony that, "additional standardized patient assessment data are needed to test risk-based models on larger samples." What type of additional data needs to be collected?

Ms. MORLEY. So the work that we have been doing with ASPE over the last several years has been work based on the post-acute care payment reform demonstration data where care data were collected on about 200 providers across the country between 2008 and 2010. That data has been very useful for developing the framework for a risk adjustor, but we have been unable to look at subpopulations of patient diagnoses and to get a broader national understanding of how these models might differ for patients across the country.

Mr. PITTS. Dr. Hammerman, what can Congress do to ensure range of post-acute providers, as you state in your written testimony?

Dr. HAMMERMAN. I am sorry, could you repeat that question?

Mr. PITTS. Yes, what can Congress do to ensure a range of post-acute care providers, as you state in your written testimony?

Dr. HAMMERMAN. So I believe that in a sense, being that the information is being provided via the IMPACT tool, i.e., functional assessments that will be looked at, in addition to the bundling projects that are under way, there will be data to be able to differentiate patients one from another, from the higher acuity patients that we currently manage in the long-term acute care hospital setting, as well as inpatient rehabilitation setting, as well as the lower acuity patients that goes to a skilled setting or cared for in a home environment.

Mr. PITTS. Dr. Landers, in what ways would condition-related groups, or CRGs, align incentives for improved outcomes and reduce cost?

Dr. LANDERS. The CRG model would create an incentive for the coordinators to look at care across the different venues of care that patients might be in, so that we can focus on having individuals in the most appropriate setting but also the most cost-effective setting, and that should both address quality and cost.

Mr. PITTS. Mr. Russ, in your opinion, do you believe CMS' quality improvement star rating system for PAC providers has improved the quality of care in the PAC setting?

Mr. RUSS. Well, I wouldn't say that in and of itself it has improved the quality of care. I think it has made the spectrum of care providers more mindful of certain metrics to adhere to which we agree help measure quality. We think some of those metrics are flawed and not properly risk adjusted, but on the other hand, we are championing quality and working collaboratively with CMS on many of the components of the five-star system and particularly with the component of five-star that deals specifically with the quality measures.

So we believe that, even though the five-star system is not perfect and we probably could come up with a better system, we are not opposed to a system that ranks and measures quality. Indeed, we are championing such a system, and we think such a system also should be an integral part of any kind of post-acute care bundling system that—the BACPAC bill, although it has some positive features such as the elimination of a 3-day hospital stay, is a bit short on ensuring quality and accountability across the spectrum, and I think pays more lip service to the notion of care coordination, and it seems to be more focused on payment coordination.

Mr. PITTS. Quickly. What is the difference between your organization's quality initiative and CMS' quality improvement star rating system?

Mr. RUSS. Well, our quality initiative is basically focused in five main areas, which CMS is mindful of, we have been working collaboratively with. They have adopted several of our quality initiative metrics or variations thereof to include in the five-star system, but we are comprised mainly so far, and we are going into the second generation of that system, so far we are focused on rehospitalization, on the reduction of off-label use of antipsychotic medication, on ensuring staff stability for the sake of continuity of care for the frail and elderly, and also focused on customer satisfaction.

Mr. PITTS. Thank you. My time is concluded. The chair recognizes the ranking member Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Morley, from Dr. Miller in our first panel, we heard MedPAC's concerns with potential stinting of care under the bundle payment design. The BACPAC Act requires the secretary to ensure that the cost of the bundles do not exceed 96 percent of the PAC expenditures that would have been made. The bill also specifies that PAC providers would be paid an amount that is not less than the amount which they would otherwise be paid. In other words, the bundles have to reduce cost without cutting provider payments.

It seems to me that savings can only be generated by reducing prices in volume. The legislation, however, does not allow for price reductions; therefore, savings that come from volume reduction are less care. My first question. Could you discuss the dangers of bundles incentivizing stinting of the care or what we might do with it or do about it?

Ms. MORLEY. Yes. I think one of the most important considerations here is the risk for stinting and cost shifting. This is always a concern when setting a prospective payment. So to the extent possible, we want to protect against stinting and cost shifting with strong quality measures. In combination with a payment incentive

under a bundled payment, quality measures can incentivize providers to deliver the most appropriate care and to achieve high quality beneficiary outcomes.

Mr. GREEN. Can you speak about the potential effects of reducing the volume of services that beneficiaries receive?

Ms. MORLEY. I think, again, back to the stinting and cost shifting. Without strong quality measures, there is an incentive to deliver fewer services in order to maximize the savings over the bundle for the entity holding the bundle, but I do think that with the quality measures in place, there can be—these incentives can be changed to protect beneficiaries.

Mr. GREEN. OK. You also mention that—your testimony, a potential that services may be required outside the 90-day window established by the BACPAC. Does the BACPAC require PAC coordinators to pay for their services needed after the 90-day period? Since PAC coordinators are on the hook financially for only those services within that 90-day window, is it possible we may delay certain services until that window has been ended?

Ms. MORLEY. To my knowledge, it seems that the PAC coordinators would not be responsible for services after the 90-day period, but it is possible that there would be an incentive to delay services to that post 90-day window unless those quality measures were in place to incent providers otherwise. We know from earlier research that the majority of service used is generally complete by a 90-day period, but there is some service use that does continue after 90 days for—especially for medically complex patients, so if episodes end and services continue, information may be needed to set payments for those remaining services.

Mr. GREEN. OK. The other concern about this is the financial incentive to stand on care and incent the least expensive setting. For example, under the BACPAC, the PAC coordinators would be able to keep mostof any savings they achieve. In other words, if a certain episode bundle is $1,000, the coordinator may spend only 600 on the beneficiary, so there is a $400 difference. Does this not make this profit contingent on meeting certain minimum quality thresholds?

Ms. MORLEY. I think that the strong quality measures need to be put in place to reduce stay incentive for cost shifting, stinting and potentially adverse beneficiary outcomes. Some potential quality measures that could be considered would be related to functional outcomes, cognitive status outcomes, or other items related to stint integrity as examples.

Mr. GREEN. I guess we need to have those quality controls there because a coordinator could profit from bundling those patients to the least expensive setting as opposed to more clinically appropriate, so there has to be some guidelines there.

So Mr. Chairman, I yield back my time.

Mr. PITTS. The chair thanks the gentleman. Now recognize the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. Thank you all for being here. Sorry we were disrupted in the middle, but we had to go vote.

Dr. Morley, I want to ask you, do you think it is possible to establish episode-based programs while still including long-term care hospitals in the equation?

Ms. MORLEY. I do, but I think, as I state in my testimony, I think it is going to take a lot of research and understanding of patterns of care, so that there is an understanding that these services are not uniformly available across the country. There will need to be specific geographic market adjustments so that beneficiaries will have access to use the services that they need, but I think it is possible to, you know, to find a way to include all settings.

Mr. GUTHRIE. Thank you. And also for you, Dr. Morley. What ideas do you have for reforming this space outside of bundled payments? Is that the only option or are there others?

Ms. MORLEY. I think another option that has been discussed and discussed this morning, as you know, move to site neutral payments. That is a way to move beneficiaries to move providers to a space where they are thinking about what care is needed for this beneficiary, regardless of setting, and I think setting neutral payments is separate from bundling but is another approach.

Mr. GUTHRIE. Thank you. And Dr. Hammerman, do you believe that bundled paymentsand other types of reforms with the same philosophy have the potential to reduce necessary care, and if so, what steps would you recommend policymakers to mitigate these concerns?

Dr. HAMMERMAN. Thank you. I think that, in general, the way that the long-term acute care hospital environment evaluates what is available from a bundling perspective, we need to strongly consider that the manifestation from the ICU patient population will continue to grow. The chronically, critically ill patient population will continue to grow, so any bundled strategy that takes effect will have to keep in mind that this patient population will be significant in both the near and long term.

Recommendations are certainly in the realm of looking at these functional assessment tools and making certain that we keep in mind with this catastrophically ill patient population that the first venue is extraordinarily important to move forward because, as we know from the critical literature and as a practicing pulmonary critical care physician, that the return to an ICU from a post-acute setting can increase the mortality five- to tenfold, not just 5 to 10 percent. So I think any bundling strategy that we would look at in the future has to keep that in mind from a very strong clinical perspective.

In our opinion, the clinician at the bedside working with the interdisciplinary team has ultimately the largest priority in terms of making certain that we put patients in the right venue at the right time for the right reason.

Mr. GUTHRIE. OK. Well, thank you both for your answers, and thank the panel for their testimony, and I yield back my time.

Mr. PITTS. The chair thanks the gentleman. Now recognize the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you very much. And thank you, Mr. Chairman, for holding this hearing, all of the witnesses for your testimony.

I am pleased that we are here today to discuss post-acute care. I know how important this care is for patients who need continued medical attention. From long-term hospitals to home health providers, the various post-acute care providers all, each discipline offers essential healthcare services. I think we all agree that the way that post-acute care is delivered and paid for needs improvement.

There are many elements that go into making a high quality cost-effective system, and as with any change to Medicare, we must carefully consider the impact a policy change will have on the quality of care and access to care for patients. We first must need to gain a better understanding about how to measure quality of care across the different post-acute care settings.

Dr. Hammerman, in your testimony, you point out that the ACA put in place many important stepping stones for PAC, post-acute care reform. Currently, Medicare is testing and advancing a number of payment system reforms for post-acute care, including bundled payments and value-based purchasing.

So my first question to you, Dr. Hammerman, is to ask you to describe some of the bundling demonstrations that have been created under the ACA and what we are learning from them so far. That is just the first of a few questions I have.

Dr. HAMMERMAN. Certainly. I think I can speak in a very limited fashion in terms of from a long-term acute care hospital perspective, not overall in terms of a grander scheme of the BPCI projects. From that perspective, we have limited participation at this point from an LTACH perspective but more of a larger perspective from——

Mrs. CAPPS. Excuse me, LTACH? Long-term care facility.

Dr. HAMMERMAN. I am sorry. Long-term acute care hospital standpoint.

Mrs. CAPPS. Oh, got you.

Dr. HAMMERMAN. So we have some experience in that realm, and I am happy to get further data for you offline as well.

Mrs. CAPPS. Awesome. As a nurse, I am always concerned about how policies that reform payments will affect the quality of care to patients, and demonstrations from the Affordable Care Act are going to be crucial to providing some of the information we need to measure quality across PAC providers, but more work is needed, and I look forward to any information you can supply.

My second question has to do with data from the IMPACT Act. While I share the concern of my colleagues that we must address the current challenges with post-acute care payments, it is important to look at the facts and examine the strategy you have already made. When the IMPACT Act was passed in the last Congress with strong bipartisan support, we ensured that post-acute care data could be standardized.

This standardization allows for the comparison of patient assessment data across the various types of providers. Dr. Hammerman, in your testimony, you attested to the ability of this bill to help develop an informed and evidence-based post-acute care bundling system.

Do we have all the data yet that the IMPACT Act might provide? If not, what kind of information might we learn about measuring quality of care in PACs? And if this is something that you would

rather refer to one of your colleagues there, that is fine with me, too.

Dr. HAMMERMAN. Certainly. I can do that. From speaking from the long-term acute care hospital perspective, that data will be and is valuable to the next steps in terms of a bundling strategy, but I am happy to ask one of our colleagues, perhaps Dr. Morley, to comment on the IMPACT Act, or Dr. Landers.

Ms. MORLEY. I can comment really to the IMPACT Act data. It is my understanding that there will be a phase in related to the data collection and that some of the first sets of data for SNF, IRF, and LTCH will be available in 2018 and home health in 2019. I think that one year of data would be ideal in order to be able to analyze and support the development of a payment system.

Mrs. CAPPS. Did you want to add one——

Dr. LANDERS. I would just like to disagree with the notion that we need more time and a lot more data to begin improving post-acute care. I think that there are a lot of people that are struggling right now with uncoordinated care and there are unnecessary costs, and also I want to point out that the Affordable Care Act and also the recent SGR fix, which incentivizes physicians to enter into alternative payment models, has greatly accelerated the adoption of what are called accountable care organizations or Medicare——

Mrs. CAPPS. Right.

Dr. LANDERS [continuing]. Savings programs. Across the country right now, as we speak, we are seeing consolidation of health systems, we are seeing people aligned along the strategy of these accountable care organizations, and within them, they are making some pretty aggressive changes to how post-acute care is delivered within those systems. And so some of the same things that people have raised concerns is would there be stinting I think it was called, and would there be inappropriate shifting, that is all happening without the thoughtful structure of something like the clinical related group that has been outlined in this law.

So I think that a lot of the things that we are concerned about happening if we move too fast are actually happening in the context of the recent reforms, and this would actually add more protections.

Mrs. CAPPS. And we need data about them, it seems. I have one more question. I don't know if there are other people waiting to speak.

Mr. PITTS. We have one, but go ahead.

Mrs. CAPPS. OK, if you don't mind, extend my time a little bit. But I think we are at a point where, then you are saying, if I may extrapolate from what you said, that we have enough data already, that we can begin organizing and making some changes based on that, not to denigrate from the fact that we probably need more data.

But Mr. Russ, I had a question for you, because my biggest concern is that without the proper information, we risk setting up a new payment system that incentivize providers to cut corners on care. I think it is clear from today that more information is needed as we look at reforming post care, even though, as you say, we have a lot of data about things that are already working and could be.

Mr. RUSS. I would simply say that I agree with that premise. I think the initiative that is being taken is to be applauded on many fronts as far as trying to move the modeling forward to create economies of scale and to create efficiencies of care delivery. But I do think that we don't have enough data to go whole-heartedly into a particular system yet where we don't know what the unintended consequences may be.

Mrs. CAPPS. Right.

Mr. RUSS. There are a lot of risks associated with it and we—at this vital time, this pivotal moment where we are moving away from fee for service and there is a consensus throughout post-acute care and through all the stakeholders and policymakers that we need to move to a better, more effective model, that we don't plunge into something that is not yet well tested and that does not have unintended consequences creating barriers to access of care and to providers participation.

Mrs. CAPPS. Thank you. Thank you for allowing me to go further.

Mr. PITTS. Sure. Thanks the gentlelady.

And now, without objection, the chair recognizes the prime sponsor of the BACPAC legislation, Mr. McKinley, 5 minutes for questions.

Ms. MCKINLEY. Thank you, Mr. Chairman. And thank you to the panel.

It was interesting how the first panel we had, they primarily were interested in cost. I saw a lot of questions had to do with cost, and the second panel you are more interested in—appropriately in quality of care and how that is going to be but——

So, let me try to address some of the issues I heard in the first panel before we went to vote is about the cost. I just want to remind everyone that I know it differs from the quality, but they need to be reminded again. This is a paid-for program with $20 to $25 billion in savings to protect our Medicare system. We also know that there have been at least three test cases of using this, both in Fresno, California and the Midwest and New England that actually have tried this model. And in all cases, the savings have been anywhere from 10 to 21 percent savings. So this thing does work on the cost side of it.

And, Dr. Hammerman, you raise the issue of readmission. And having served on a hospital board for 28 years, I am very sensitive to that. And under this particular legislation, the cost coordinator is the one that is going to be responsible for that. So let's go back to what that—the definition for those. I am sure everyone has read the bill. But under the provision, it is for the patient with the guidance of their physician, the guidance of their physician, to select their preferred provider, this coordinator. And then under the definition of the coordinator, it could be a hospital.

So when we talk about cost cutting here, we talk about cutting quality, you are challenging hospitals that they are not doing quality care because under the very bill, it says they can be the coordinator. It could be the PAC coordinator, insurer, or third-party administrator, or a combination of hospital and PAC. So there is a whole series all of which come down to the secretary will make the determination of how their qualifications are set so they could be selected to be able to provide the services. The bottom line is, we

are trying to find ways to help people find through a coordinator to get the best care for them so that they don't get readmitted to the hospital.

So, Dr. Landers, let's go back to your—it is essential, as we know, that any reform we undertake results in the improvement over the status quo of our rural communities. I come from a rural America, Wheeling, West Virginia. And in many areas all across this country, it is rural.

So we are concerned, do you anticipate that rural patients will benefit from care coordination that is provided under this model; and that the coordinators, these ones that we have described, will have full rural coverage?

Dr. LANDERS. I thank you for the question.

I think that, in order to be competitive, the coordinators are going to have to have an adequate network and they are going to have to make sure that they have providers available for the provision of services to patients in rural communities. I also would add that because you have preserved the rate and benefit model within the bundles of the current system, things like this effort to improve the rural payment like in home health services in the recent law that those have been preserved, the additional 3 percent to account for their cost, I think that there are safeguards in place to protect rural patients, yes.

Ms. MCKINLEY. One of the things that we have talked often about, as the chairman has pointed out, I don't serve on this committee as—but I am keenly interested in a lot of these issues primarily because of the waste, fraud, and abuse that we hear often used here in Washington about Medicare.

So we look at this thing. And do you think this BACPAC legislation will help weed out some of the bad actors that have perhaps been abusing this system by using a coordinator?

Dr. LANDERS. Yes. I just can't imagine the coordinator model, where the incentives are aligned for them to shepherd cost effective and high quality care, that they would engage fraudulent providers. I think this could be one of the biggest fraud prevention measures ever undertaken.

Ms. MCKINLEY. Thank you. I wanted that to come out.

And then, also, I just spoke on the floor before we came out with some of the other people that were in the committee earlier today, and we were talking about some of these issues. And one of the questions that was raised also in the first panel was, is this going to be a cost outside the system, and it is not. And I was explaining that. They hadn't had a chance to review the bill yet, and that was that this is built into the cost. So that we want to reinforce, this is not our projection, but this is from the CBO that says that, under this legislation, it scores between $10—or $20 and $25 billion and for—and it was added that we could very well be addressing some of the waste, fraud, and abuse in the system by virtue of this cleaning out the bad actors.

So I appreciate your panel and the questions raised. I think there have been some very interesting points. It is a framework. It is going to keep moving. I hope that some of the issues that you have raised can be amended and corrected and added into this leg-

islation. But we have to move forward. I don't think we want to be waiting for another 2 or 3 years before we move on this.

So I thank you, Mr. Chairman, for having this hearing and I hope that we can proceed with this legislation. Thank you.

Mr. PITTS. The chair thanks the gentleman.

Now recognizes the gentleman from California, Mr. Cardenas, for 5 minutes for questions.

Mr. CARDENAS. Thank you very much, Mr. Chairman.

Mr. Russ, you are the chair of the American Healthcare Association——

Mr. RUSS. Yes.

Mr. CARDENAS [continuing]. Otherwise known as AHCA. Your organization has developed a new payment concept for skilled nursing facilities to create your own bundle. Your payment proposal promotes patient-centered care and high quality facilities while saving the government money.

Mr. RUSS. Yes. If I could elaborate on that, even though that is not the focus of today's hearing, but I think it is part and parcel of the broader discussion about reform.

We have come up—and we are in the process of finalizing with the help of the Moran Company—an episodic payment system for our sector. That would take us away from the current fee-for-service prospective payment model. It would make our members assume greater risk for the particular care that they are given, but they would be getting what is essentially a flat payment to cover all of the services rendered under our roof in that post-acute care space in exchange for delivering quality outcomes. There would be penalties presumably associated with failure to deliver quality outcomes, and it would protect against what might be deemed the overdelivery of services now under the current fee-for-service system and yet prevent us from underdelivery of service which some people might argue could take place when a third party convenor or other entity is managing an across-the-spectrum bundle.

So we think that this is a great step forward for our sector. We don't necessarily think it is the final chapter for our sector, but we think it is the best possible iteration of change that we could muster in a path toward possible broader spectrum post-acute care bundling. It could be a step in that direction, but we really believe it will hold us more accountable. And essential to the whole system is the measurement, empirical measurement, of quality.

Mr. CARDENAS. Thank you, Mr. Russ. You testified that your organization has six guiding principles that you use to evaluate PAC bundled payment models and that the BACPAC Act either doesn't meet those principles or is unclear. One of those principles is that the policy must preserve a patient's freedom of choice of provider.

Can you speak a bit more about your specific concerns with the BACPAC Act and preserving freedom of provider choice?

Mr. RUSS. Yes. I think in the larger sense, I mean, when you have got networks that are being established, inevitably there are going to be certain providers, for whatever reason, whether they are judged on quality, whether they are judged on economic expediency, whether they are judged on their ability to provide lower cost to the care coordinator, we don't know what those incentives are going to be, but they are inherently exclusionary. They don't allow

all willing, good quality, highly rated by CMS providers to participate.

And while we may pay lip service to the notion that ultimately the patient will decide who the provider will be whom they are going to access services from, ultimately, the care coordinator is going to make that decision because they are coordinating the bundle. And so I don't necessarily see how this will enhance patient choice. I think it would probably reduce patient choice, and I think it would also reduce the ability of any willing good provider to participate in that particular bundle.

Mr. CARDENAS. So, is AHCA concerned that there is no mechanism for a beneficiary to seek PAC outside of their coordinator's network without switching to a new coordinator?

Mr. RUSS. Well, I think there are so many ambiguities in the bill as to how this would roll out. I think our overarching conclusion is that this doesn't seem to be practicable or implementable. And I think when you consider also the various demographic differences across the country—we have heard a lot about rural settings. There are urban settings. There are settings—each marketplace is driven differently by who happens to be the powerhouse in that marketplace, whether it is a hospital network, whether it is a home health agency, or whether it is a large string of skilled nursing facilities. You have got a very, very uneven playing field and a kind of nebulously conceived bundle payment package to overlay this is going to be very difficult, if not impossible to implement effectively and consistently across the country.

Mr. CARDENAS. Thank you, Mr. Russ.

Yield back my time. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. That concludes the questions from members who are present. We will have follow-up questions. I know other members who couldn't make it back will have some questions. We will submit those to you in writing. We ask that you please respond promptly.

And I remind members that they have 10 business days to submit questions for the record. Members should submit those questions by the close of business on Thursday, April 30th.

Very good hearing. Thank you very much for the information. Very important. Without objection, subcommittee is adjourned.

[Whereupon, at 1:07 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

## PREPARED STATEMENT OF HON. FRED UPTON

Modernizing and strengthening Medicare to improve care for seniors and help make it more sustainable over the long run remains a top priority for this committee. Today the Health Subcommittee will examine Medicare's payment policies for seniors utilizing post-acute care. Post-acute care—care that some of our most vulnerable seniors rely on, usually after discharge from a hospital stay—represents a fast-growing part of the Medicare benefit, having roughly doubled in cost over the last decade. With 10,000 Baby Boomers entering Medicare each day, it is essential that we understand how Medicare's current post-acute policies impact the quality of care seniors in Michigan and across the country receive.

Post-acute care providers currently face significant disparities in the range of reimbursements they receive from the Medicare program. This is, in part, a legacy of past legislative efforts designed to target resources to specialized facilities which were intended to care for more complex patients in an intensive manner. However, in recent years, continued advancements in medical technology and clinical best

practices have proven that there may be opportunities to make post-acute reimbursements more efficient, while better measuring and rewarding quality, incentivizing coordinated care, and improving seniors' care overall.

Improving post-acute care services for seniors is an area that is ripe for bipartisan agreements. From the President's FY2016 Budget, to Republican proposals, to right here in our committee, there are a range of ideas on how to increase quality, improve seniors' care, and reduce costs in a targeted manner. I would like to thank Rep. McKinley from this committee in particular for his work on H.R. 1458, the "Bundling and Coordinating Post-Acute Care Act of 2015" (BACPAC). This bipartisan bill, cosponsored by Reps. Tom Price, Jerry McNerney, and Anna Eshoo outlines a way to provide bundled payments for post-acute care services under Medicare, while protecting seniors' choices and helping coordinate care.

I look forward to continuing to work with my colleagues and the experts testifying today as we find bipartisan opportunities to improve health care for seniors. I especially want to thank Mark Miller, the director of MedPAC, and his staff for all their hard work. We continually turn to MedPAC for analysis and expertise, and we appreciate the resource he and his team are to the committee. I thank all of the witnesses for their important testimony.

**WRITTEN TESTIMONY OF THE**

**COALITION TO PRESERVE REHABILITATION**

**BEFORE THE**

**SUBCOMMITTEE ON HEALTH**
**COMMITTEE ON ENERGY AND COMMERCE**
**UNITED STATED HOUSE OF REPRESENTATIVES**

**IN CONNECTION WITH ITS HEARING ON**

# "MEDICARE POST ACUTE CARE DELIVERY AND OPTIONS TO IMPROVE IT"

**APRIL 16, 2015**

COALITION TO PRESERVE REHABILITATION
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| | |
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Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony for the record on behalf of the Coalition to Preserve Rehabilitation ("CPR") in connection with your hearing entitled, "Medicare Post Acute Care Delivery and Options to Improve It." We were fortunate to have been invited by the Subcommittee last year to testify during the hearing entitled, "Keeping the Promise: Site of Service Medicare Payment Reforms" on the issue of site-neutral payment of post-acute care ("PAC") and included significant comments at that time on the Bundling and Coordinating Post-Acute Care Act of 2014 ("BACPAC" Act). Since then, a new version of this legislation has been introduced by Congressman McKinley, H.R. 1458, which we have analyzed and submit this statement for the written record. CPR is a consumer-led, national coalition of patient, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. Members of the CPR Steering Committee include the Center for Medicare Advocacy, the National Multiple Sclerosis Society, the Brain Injury Association of America, United Spinal Association, and the Christopher and Dana Reeve Foundation.

**Medicare PAC Payment Reform Requires Serious Deliberation and Reliable Data**

All Medicare post-acute care reforms that Congress considers should, first and foremost, preserve access to quality rehabilitation services provided at the appropriate level of intensity, in the right setting, and at the right time to meet the individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation and should be based on reliable data that is comparable from one PAC setting to another. Uniform and current data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. The Improving Medicare Post-Acute Care Transformation ("IMPACT") Act of 2014, signed by the President into law last October, now serves that data collection purpose. We request Congress give the Centers for Medicare and Medicaid Services (CMS) sufficient time to collect data under the IMPACT Act's provisions before adopting a short-term, underdeveloped, approach to bundled payments impacting the recovery and rehabilitation of some of Medicare's most vulnerable beneficiaries.

**BACPAC Act of 2015**

The current version of the BACPAC Act of 2015 (H.R. 1458) has some significant changes from the previous legislation by the same name, but the overall bill is the same. The legislation seeks to bundle payments for Medicare post-acute care services (including SNF and extended care services, home health, inpatient rehabilitation hospital care, long term acute hospital care, durable medical equipment, and outpatient prescription drugs). Unlike its predecessor, the BACPAC Act of 2014 (H.R. 3796), the current Act includes in the bundle outpatient physical therapy services and outpatient occupational therapy services, but retains outpatient speech-language pathology services outside of the bundle. Exceptions to the bundle include physicians' services, hospice care, outpatient hospital services, ambulance services, outpatient speech-language pathology services, and orthotics and prosthetics. The bundled payment could be held by any entity that demonstrates the financial capacity to direct Medicare beneficiaries' PAC care including acute care hospitals, insurance companies, third-party administrators, and PAC providers.

We favor systems based on sound evidence with fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care. Unfortunately, a bundled PAC payment system that includes these critical beneficiary protections does not exist and, we expect, will take several years to develop, adequately test, and validate. This is why we support existing bipartisan efforts led by Rep. Martha Roby and Rep. Bill Pascrell to refrain from legislating site-neutral PAC payments or take other PAC reform actions until data is collected and analyzed under the authorities enacted in the IMPACT Act. This data can be used to develop a uniform quality assessment instrument to measure outcomes across PAC settings; such a tool would be invaluable to enacting PAC reforms that do not compromise patient care. This is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC patients under a bundled Medicare payment system achieve good patient outcomes and risk adjusters accurately capture the unique needs of individual patients.

Until these and other patient protections are in place, we do not support legislating broad PAC bundling reforms that lock-in federal savings and defer to the HHS Secretary to implement broadly outlined bundling authorities. It is simply too risky to Medicare beneficiaries to implement PAC bundling prematurely. In addition, there are a number of comments we wish to make with respect to the BACPAC Act of 2015.

1. **Use of Medicare Rates for Qualifying PAC Services:** In BACPAC Act of 2015, bundle holders are required to pay Medicare PAC providers Medicare rates[1] rather than negotiated rates for covered PAC services, as permitted in the H.R. 3796. CPR supports this improvement in the new version of the bill. Given the fact that the bill also allows the bundle holder to be an acute care hospital, an insurer, or a third party administrator, CPR had serious concerns that negotiated rates with PAC providers under the bundle could have led to a race to the bottom in terms of the quality of providers serving beneficiaries under the bundle. The requirement to pay providers Medicare rates forces providers to compete based on quality, reputation, and high levels of service which accrue to the benefit of patients. However, given the fact that the new BACPAC Act also requires the bundled payment to equate to 96% of the average cost of a given episode of treatment, thereby saving the government significant PAC expenditures, CPR questions how the bundle holder is going to achieve these savings. If such savings are borne on the backs of Medicare beneficiaries by being denied access to more intensive, coordinated, or advanced rehabilitative treatments, then CPR has serious concerns with this outcome.
2. **PAC Coordinator ("PAC Bundle Holder"):** We also have serious reservations with the proposal to permit acute care hospitals, insurance companies, and third-party administrators to serve as the holder of the PAC bundle for the 90-day bundling period. Regardless of their ability to assume the risk, there are strong incentives in such a model for entities with little direct knowledge of rehabilitation to divert patients to the least costly PAC setting, as long as these patients are not readmitted to the acute care hospital, which comes with financial penalties. Current law requires the Centers for Medicare and Medicaid Services (CMS) to pilot test a concept known as the Continuing Care Hospital (CCH),[2] where the PAC bundle is held by a combination of post-acute care providers (i.e., LTACH, IRF and hospital-based SNF). This would, at least, place the bundle in the hands of providers who understand rehabilitation and these patients' needs. At a minimum, insurers and third party administrators should not be eligible to hold the bundle. This would be akin to joining a

[1] See BACPAC Act of 2015, page 14: "For PAC services furnished by a PAC provider and furnished with respect to a qualifying discharge, the entity shall pay the PAC provider under the PAC network agreement between the entity and the PAC provider—"(i) *with respect to such PAC services that are services for which the PAC provider would receive payment under this title without regard to this section, an amount that is not less than the amount that would otherwise be paid to such PAC provider under this title for such services…*" [Emphasis added].

[2] Inexplicably, CMS has not yet pursued the mandated CCH pilot program.

managed care plan (for purposes of PAC services) within the fee-for-service Medicare program. If beneficiaries wish to join Medicare Advantage, that option is certainly available to them, but this concept should not be permitted to apply to fee-for-service. That being said, CPR supports the BACPAC Act's new language suggesting that the PAC bundle holder is accountable for the achievement of quality and outcome measures to protect against underservice.[3]

3. **Entities Able to Assume Risk**: Any PAC bundle holder must be truly able to assume the risk of holding this bundled payment while providing services to a beneficiary across a 90-day episode of care. While financial solvency is mentioned broadly as a requirement of the PAC bundle holder,[4] financial solvency, transparency, appropriate governance, accountability, and related standards should be more explicitly adopted in the legislation to ensure that PAC bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. Such standards are readily available and well validated through a number of accreditation organizations that specialize in quality improvement and accountability of post-acute care, such as the standards developed by the Commission on Accreditation of Rehabilitation Facilities (CARF) or other appropriate accreditors.
4. **PAC Physician**: The BACPAC Act defines a "PAC Physician" as having primary responsibility with respect to supervising the delivery of the services during the PAC episode. We support a requirement that the health care professional making treatment decisions be a clinician rather than a layperson, but the bill should require this physician to have experience in post-acute care/rehabilitation service delivery, as this is the very expertise necessary to develop and implement PAC treatment plans.
5. **Outpatient PT, OT, and SLT Services Should All be Exempt from the Bundle:** Outpatient physical therapy services and outpatient occupational therapy services were previously excluded from the bundle in the BACPAC Act of 2014, but are now included in the BACPAC Act of 2015. However, speech-language pathology services remain exempt from the bundled payment. We question the reason for this change in the new bill. Outpatient PT, OT, and speech-language pathology services are critical to the long term

[3] See BACPAC Act of 2015, pages 12-13, regarding quality assurance, PAC coordinator performance, and care coordination.
[4] See BACPAC Act of 2015, page 10.

outcomes of Medicare beneficiaries in need of rehabilitation following illness or injury. Including any of these services in the bundled payment will serve as a cap in services that will penalize those beneficiaries most in need of rehabilitation. We support the exclusion from the bundle of all outpatient therapy services as originally proposed in the 2014 BACPAC legislation. Medicare beneficiaries needing rehabilitation services must have access to quality therapy services at the appropriate amount, duration and scope to meet patient needs.

6. **All Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle**: CPR supports the exclusion from the bundle of all prosthetic limbs and orthopedic braces, as is the case under the previous and current BACPAC Act. CPR would also support a further exclusion of customized durable medical equipment, particularly mobility devices known as "complex rehabilitative technology" or "CRT"[5] as well as Speech Generating Devices (SGD's). CPR believes that certain devices and related services should be exempt from the bundled PAC payment system as they are critical to an individual in returning to full function and would likely be delayed or denied under a bundled payment system. All customized devices (such as prosthetics, orthotics, CRT and SGDs) that are relatively expensive and intended to be used by only one person should be separately billable to Medicare Part B during the 90-day bundled period. These devices and related services are critical to the health and full function of people with limb loss and other disabling conditions. Not all Medicare beneficiaries require prosthetics, orthotics, CRT and/or SGDs, but these devices are critical to the health and function of some patients. Under a bundled payment system, there are strong financial incentives to delay or deny entirely access to these devices and related services until the bundle period lapses. Once this occurs, Medicare Part B would be available to cover the cost of these devices, but this delay is very deleterious to patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the PAC stay.

   This phenomenon was witnessed when Congress implemented prospective payment for skilled nursing facilities ("SNFs") in 1997 and initially included orthotics and prosthetics in

[5] Bipartisan legislation has been introduced in both houses of Congress to create a separate designation under the Medicare program for CRT entitled, "Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013," H.R. 942 and S. 948.

the SNF bundle or prospective payment system ("PPS").[6] As a result, most skilled nursing facilities began to delay and deny access to prosthetic and orthotic care until the beneficiary was discharged from the SNF and then Medicare Part B assumed the cost of O&P treatment. During this period, Medicare patients experienced inappropriate and unreasonable delays in access to orthotic and prosthetic care that often make the difference between independent function and life in a nursing home. In 1999, Congress recognized this problem and exempted a large number of prosthetic limb codes from the SNF PPS consolidated billing requirement,[7] thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.[8] As a result, SNF patients once again had access to prosthetic care during the course of their SNF stay. This experience should not be repeated under new bundled payment systems and, therefore, we recommend that Congress exempt all prosthetics, custom orthotics, CRT and SGDs from any PAC bundling legislation.

7. **Exemption of Certain Vulnerable Patients from First Phase of Bundling**: PAC bundling is a concept that is clearly untested at this time, and we strongly favor fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care to protect vulnerable Medicare beneficiaries. Among these Medicare patients are people with brain injuries, spinal cord injuries, moderate to severe strokes, multiple-limb trauma, amputations, and severe neuromuscular and musculoskeletal conditions. While this is clearly a minority of Medicare beneficiaries, it is a very important subgroup that, we believe, should be exempt from the first phases of any bundled payment system. While such groups of patients could be phased-in at the patient's option as bundling develops, we believe the most vulnerable patients should only be included in PAC bundling on a mandatory basis when the bundled payment systems can demonstrate sufficient quality outcomes, risk adjusters, and patient safeguards to ensure quality care.
8. **Appropriate PAC Quality and Outcome Measures**: Quality measures must be mandated in any PAC bundling bill to assess whether patients have proper access to necessary care.

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[6] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414 –22 (1997) (codified at 42 U.S.C § 1395yy).
[7] Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, § 103, 113 Stat. 1501A-321, 1501A-325–26 (1999) (codified at 42 U.S.C § 1395yy(e)).
[8] Unfortunately, Congress did not similarly exempt custom orthotics from the SNF consolidated billing requirements which has led to a serious lack of access to appropriate custom orthotic care in the SNF setting.

This is one of the most important methods of determining whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. The current BACPAC Act only mentions that the PAC Coordinators "ha[ve] in effect a written plan of quality assurance and improvement, and procedures implementing such plan, that meet quality standards as the Secretary may specify."[9] But the truth is that uniform quality and outcome measures that cross the various PAC settings do not currently exist. The existing LTACH CARE instrument for LTACHs, the IRF-PAI for rehabilitation hospitals, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies, are all appropriate measurement tools for each of these settings. But they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute care episode of care. For instance, before widespread PAC bundling is adopted, measures must be incorporated into the PAC system as follows:

- Function: Incorporate and require the use of measures and measurement tools focused on functional outcomes, and include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
- Quality of Life: Require the use of quality of life outcomes (measures that assess a return to life roles and activities, return to work if appropriate, reintegration in community living, level of independence, social interaction, etc.);[10]
- Individual Performance: Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the "average" patient;
- Access and Choice: Measures should include assessment of whether the patient has appropriate access to the right setting of care at the right time and whether the patient is able to exercise meaningful choice; and
- Patient Satisfaction: Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of

[9] See BACPAC Act of 2015, page 12-13.
[10] These extended functional assessment and quality of life measures are consistent with the World Health Organization's International Classification of Function, Disability and Health (ICF) and the measurement tool designed around the WHO-ICF known as the AM-PAC.

outcomes. CMS or MedPAC should be required to contract with an independent entity to conduct studies in this area and factor the results into any final PAC bundled payment system in the future.[11]

9. **Create Financial Disincentives Preventing Clinically Inappropriate Diversion of Patients to Less Intensive Settings**: In order to protect against diversion of patients to less intensive, inappropriate PAC settings, we recommend that any PAC bundling legislation include instructions to the HHS Secretary that payment penalties should be established to dissuade PAC bundle holders from underserving patients.

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The disability and rehabilitation community understands the magnitude of the problem that our nation faces in attempting to contain federal health care spending. However, achieving federal savings through what we believe to be short-sighted, underdeveloped, and untested post-acute care reforms that do not adequately take into account long-term cost-effectiveness, maximal patient outcomes, and the future capacity of our rehabilitation system to continue serving our most challenging Medicare beneficiaries, is not the path to success. Therefore, bundling of payment of PAC services should not proceed without significant improvements and safeguards being added to the current BACPAC Act, and without first gathering significant data from the IMPACT Act to fully inform the design of bundling in a manner that does not stint on patient care. Such post-acute care reform should incentivize good outcomes for patients, not just cost savings.

Thank you for the opportunity to submit written testimony on this important issue.

[11] "uSPEQ"® (pronounced "You Speak") is an example of a patient satisfaction assessment tool developed by CARF, International, that measures end users' experience with post-acute care. The survey can be answered by the patient, family or caregiver.

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**WRITTEN TESTIMONY OF THE**

**ORTHOTIC & PROSTHETIC ALLIANCE**

**BEFORE THE**

**SUBCOMMITTEE ON HEALTH**
**COMMITTEE ON ENERGY AND COMMERCE**
**UNITED STATED HOUSE OF REPRESENTATIVES**

**WITH RESPECT TO ITS HEARING ON**

# "MEDICARE POST-ACUTE CARE DELIVERY AND OPTIONS TO IMPROVE IT"

**APRIL 16, 2015**

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Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony for the record on behalf of the Orthotic and Prosthetic Alliance (O&P Alliance) and the Amputee Coalition in connection with your hearing entitled, "Medicare Post-Acute Care Delivery and Options to Improve It." The O&P Alliance is a coalition of the five major national orthotic and prosthetic organizations representing over 13,000 O&P professionals and 3,575 accredited O&P clinics across the country. The Amputee Coalition is the nation's only national consumer association solely representing the interests of individuals with limb loss, many of whom require prosthetic and orthotic care.

We have serious concerns with bundling proposals of Medicare post-acute care (PAC) services and wish to express our views on this topic. More specifically, we wish to address the Bundling and Coordinating Post-Acute Care Act of 2015 ("BACPAC" Act), H.R. 1458. We believe this legislation has been improved since it was last introduced by Congressman McKinley in the 113th Congress as H.R. 1458, and we applaud Congressman McKinley including an exemption from the post-acute care bundle in his bill for orthotics and prosthetics. However, without more reliable data that is comparable across settings of post-acute care, better quality measures, sufficient pilot testing of the concept of bundling, and other factors described below, we continue to have grave concerns with this approach to post-acute care reform and the impact it may have on Medicare beneficiaries with limb loss and orthopedic conditions who are in need of orthotic and prosthetic care.

**Medicare PAC Bundling is Premature and Requires Additional Data**

Above all, any PAC reform that Congress enacts should ensure that Medicare beneficiaries have continued access to the amount, duration and scope of rehabilitation services and devices they need to maximize their recovery from injury or illness. Access to timely and quality orthotic and prosthetic care is a critical element of PAC services that must be preserved in any PAC payment reform proposal. Given the untested and unproven concept of bundling and the relative lack of reliable treatment and outcomes data that cuts across all PAC settings, we believe Medicare PAC bundling is premature at this time. The O&P Alliance and the Amputee Coalition is very concerned that Congress may enact a framework of bundling that places tremendous discretion with the Secretary of Health and Human Services to make many of the difficult decisions.

We urge Congress not to take this approach. Instead, we urge Congress to refrain from PAC reforms until data can be collected and analyzed pursuant to the Improving Medicare Post-Acute Care Transformation ("IMPACT") Act of 2014. This legislation was signed into law by the President last October and now serves as the framework for PAC data collection across all settings of post-acute care. Uniform and current data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. We request that Congress give the Centers for Medicare and Medicaid Services (CMS) sufficient time to collect data under the IMPACT Act's provisions before adopting a short-term, underdeveloped, approach to bundled payments impacting the recovery and rehabilitation of some of Medicare's most vulnerable beneficiaries.

**BACPAC Act of 2015**

The current version of the BACPAC Act of 2015 (H.R. 1458) has some significant improvements from the previous legislation by the same name. The legislation seeks to bundle payments for Medicare post-acute care services (including extended care services, home health, inpatient rehabilitation hospital care, long term acute hospital care, skilled nursing facility care, durable medical equipment, outpatient prescription drugs, and outpatient physical and occupational therapy services). Exceptions to the bundle include physicians' services, hospice care, outpatient hospital services, ambulance services, outpatient speech-language pathology services, and orthotics and prosthetics. The bundled payment could be held by any entity that demonstrates the financial capacity to direct Medicare beneficiaries' PAC care including acute care hospitals, insurance companies, third-party administrators, and PAC providers. With respect to H.R. 1458, O&P Alliance and the Amputee Coalition would like to share the comments below.

- **All Prosthetics and Orthotics Should Be Exempt from the Bundle**: The O&P Alliance and the Amputee Coalition supports the exclusion from the bundle of all prosthetic limbs and orthopedic braces, as is the case under the previous and current BACPAC Act. We believe that certain devices and related services should be exempt from the bundled PAC payment system as they are critical to an individual in returning to full function and would likely be delayed or denied under a bundled payment system. Orthotics and prosthetics for individuals with limb loss and other injuries can be relatively expensive and are useful only to one person. They are not appropriate for repeated use by multiple patients, as is the case with many forms of

durable medical equipment. In order to prevent financial incentives for bundle holders to delay access to this important care, orthotics and prosthetics should be separately billable to Medicare Part B during the 90-day bundled period and, therefore, we support the exclusion of these services from the bundle in the BACPAC Act.

These devices and related services are critical to the health and full function of people with limb loss and other disabling conditions. Prosthetics and orthotics serve the individual needs of relatively few patients under the Medicare program. Under a bundled payment system, there are strong financial incentives to delay or deny entirely access to these devices and related services until the bundle period lapses. Once this occurs, Medicare Part B would be available to cover the cost of these devices, but this delay is very deleterious to patient outcomes, and opportunities are lost for rehabilitation and training on the use of the prosthesis or orthosis during the PAC stay.

This phenomenon was witnessed when Congress implemented prospective payment for skilled nursing facilities ("SNFs") in 1997 and initially included orthotics and prosthetics in the SNF "bundle" or prospective payment system ("PPS").[1] As a result, most skilled nursing facilities began to delay and deny access to prosthetic and orthotic care until the beneficiary was discharged from the SNF and then Medicare Part B assumed the cost of O&P treatment. During this period, Medicare patients experienced inappropriate and unreasonable delays in access to

[1] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414 –22 (1997) (codified at 42 U.S.C § 1395yy).

orthotic and prosthetic care that often make the difference between independent function and life in a nursing home. In 1999, Congress recognized this problem and exempted a large number of prosthetic limb codes from the SNF PPS consolidated billing requirement,[2] thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.[3] As a result, SNF patients once again had access to prosthetic care during the course of their SNF stay. This experience should not be repeated under new bundled payment systems and, therefore, we urge Congress to retain the exemption of all prosthetics and orthotics from any bundled PAC reform proposal, including the BACPAC Act.

- **Use of Medicare Rates for PAC Service Providers:** In BACPAC Act of 2015, bundle holders are required to pay Medicare PAC providers Medicare rates[4] rather than negotiated rates for covered PAC services, as permitted in the previous bill, H.R. 3796. The O&P Alliance and the Amputee Coalition supports this improvement in the new version of the bill. Given the fact that the bill also allows the bundle holder to be an acute care hospital, an insurer, or a third party administrator, we have serious concerns that negotiated rates between the bundle holder and PAC providers would have led to a "race to the bottom" in terms of the quality of providers serving beneficiaries under the bundle, including O&P providers.

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[2] Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, § 103, 113 Stat. 1501A-321, 1501A-325-26 (1999) (codified at 42 U.S.C § 1395yy(e)).

[3] Unfortunately, Congress did not similarly exempt custom orthotics from the SNF consolidated billing requirements which has led to a serious lack of access to appropriate custom orthotic care in the SNF setting.

[4] See BACPAC Act of 2015, page 14: "For PAC services furnished by a PAC provider and furnished with respect to a qualifying discharge, the entity shall pay the PAC provider under the PAC network agreement between the entity and the PAC provider—"(i) *with respect to such PAC services that are services for which the PAC provider would receive payment under this title without regard to this section, an amount that is not less than the amount that would otherwise be paid to such PAC provider under this title for such services...*" [Emphasis added].

The requirement to pay providers Medicare rates forces providers to compete based on quality, reputation, and high levels of service which accrue to the benefit of patients. However, given the fact that the new BACPAC Act also requires the bundled payment amount to equate to only 96% of the average cost of a given episode of care, thereby saving the government significant PAC expenditures, the O&P Alliance and the Amputee Coalition questions how the bundle holder is going to achieve these savings. If such savings are borne on the backs of Medicare beneficiaries by being denied access to appropriate O&P technology, or delayed access to O&P care altogether, then we have serious concerns with this outcome and would urge Congress to reduce the amount of mandated savings to be achieved by bundling.

- **PAC Coordinator ("PAC Bundle Holder"):** We also have serious reservations with the proposal to permit acute care hospitals, insurance companies, and third-party administrators to serve as the holder of the PAC bundle for the 90-day bundling period. Regardless of their ability to assume the risk, there are strong incentives in such a model for entities with little direct knowledge of medical rehabilitation, orthotics and prosthetics, or rehabilitation therapies, to divert patients to the least costly PAC setting and delay access to O&P care, as long as these patients are not readmitted to the acute care hospital, which comes with financial penalties. Because of these incentives, we would support the removal of insurers and third party administrators as being eligible to hold the bundle. The bundle holder must have expertise in the clinical area being administered, namely, post-acute care. That

being said, the O&P Alliance and the Amputee Coalition supports the BACPAC Act's new language suggesting that the PAC bundle holder is accountable for the achievement of quality and outcome measures to protect against underservice.[5]

- **PAC Physician**: The BACPAC Act defines a "PAC Physician" as having primary responsibility with respect to supervising the delivery of the services during the PAC episode. We support a requirement that the health care professional making treatment decisions be a clinician rather than a layperson, but the bill should require this physician to have experience in post-acute care/rehabilitation service delivery, including treatment of individuals with limb loss and other neuromuscular and musculoskeletal conditions, as this is the precise expertise that is often necessary to develop and implement PAC treatment plans.
- **Exemption of Certain Vulnerable Patients from First Phase of Bundling**: PAC bundling is a concept that is clearly untested at this time and, therefore, we strongly believe that safeguards must be included in any PAC bundling legislation to protect vulnerable Medicare beneficiaries. Among these Medicare patients are people with limb amputations and multi-limb trauma, brain injuries, spinal cord injuries, moderate to severe strokes, and severe neuromuscular and musculoskeletal conditions. While this is clearly a minority of Medicare beneficiaries, it is a very important subgroup that, we believe, should be exempt from the first phases of any bundled payment system. While such groups of patients could be phased-in at the patient's option as bundling develops, we believe the most vulnerable patients

[5] See BACPAC Act of 2015, pages 12-13, regarding quality assurance, PAC coordinator performance, and care coordination.

should not be included in PAC bundling on a mandatory basis unless and until the bundled payment systems can demonstrate sufficient quality outcomes, meaningful and accurate risk adjustment mechanisms, and patient safeguards to ensure high quality care.

- **Choice of Provider within Bundled Payment Systems:** Under the current Medicare fee-for-service system, patient choice of provider is a hallmark of the program and a major beneficiary protection. Providers under bundled payment systems will have access to patients that may lead to life-long patient-provider relationships that last far longer than the initial 90-day bundled period. This is critical with the provision of prosthetic and orthotic care, where an intimate professional relationship often forms between the prosthetist/orthotist and the patient. It is critical to maintain patient choice of provider and ensure that bundled payment systems have appropriate network adequacy standards to ensure this choice of provider is meaningful.
- **Appropriate PAC Quality and Outcome Measures**: Quality measures must be mandated in any PAC bundling bill to assess whether patients have proper access to necessary care. This is one of the most important methods of determining whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. The current BACPAC Act only mentions that the PAC Coordinators have "in effect a written plan of quality assurance and improvement, and procedures implementing such plan, that meet quality standards as the

Secretary may specify."[6] We do not believe this language is sufficient to ensure that quality and outcomes are being accurately measured under bundled payment systems and we urge Congress to strengthen this language.

Before PAC bundling is enacted and implemented, measures must be incorporated into the PAC system address the following:

- Function: Bundled payment systems must incorporate and require the use of measures and measurement tools focused on functional outcomes, and include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
- Quality of Life: Bundled payment systems must require the use of quality of life outcomes (measures that assess a return to life roles and activities, return to work if appropriate, reintegration in community living, level of independence, social interaction, etc.). These are the key measures to truly assess the outcomes of individuals with limb loss and other conditions requiring prosthetic and orthotic care;[7]
- Patient Satisfaction: Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of outcomes. CMS or MedPAC should be required to contract with an independent entity to conduct studies in this area and factor the results into any final PAC bundled payment system in the future.

[6] See BACPAC Act of 2015, page 12-13.
[7] These extended functional assessment and quality of life measures are consistent with the World Health Organization's International Classification of Function, Disability and Health (ICF) and the measurement tool designed around the WHO-ICF known as the AM-PAC.

The orthotic and prosthetic community understands the magnitude of the problem that our nation faces in attempting to contain federal health care spending. But we do not believe that federal savings should be achieved through what we believe to be untested and underdeveloped post-acute care reforms that do not adequately take into account long-term cost-effectiveness and maximal patient outcomes. Therefore, of greatest importance, we endorse wholeheartedly the inclusion of the exemption to keep orthotic and prosthetic services out of any bundled payment approach, in recognition of both the fact that this patient care involves establishment and patient choice of a lifetime care provider responsible for assisting and maximizing patient mobility, AND in recognition of just how important that mobility is to maintaining vitality, health and productivity of patients who unfortunately must already shoulder the very substantial burdens of limb loss or limb/mobility impairment. Bundling of PAC services should not proceed unless and until significant improvements and safeguards are in place in the BACPAC Act and any other PAC proposal. PAC reforms should be based on reliable data that cuts across all PAC settings (i.e., data from the IMPACT Act) in order to fully inform the design of bundling or any other PAC reform in a manner that does not delay or deny patients the care they need and deserve. Such post-acute care reform should incentivize good outcomes for patients, not just cost savings.

Thank you for the opportunity to submit written testimony on this important issue.


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**STATEMENT SUBMITTED BY**

**THE NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE**

**TO THE**

**HOUSE ENERGY AND COMMERCE**

**SUBCOMMITTEE ON HEALTH**

**APRIL 16, 2015**

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the House Energy and Commerce Subcommittee on Health reviews Medicare post-acute care delivery and options to improve it, including the Bundling and Coordinating Post-Acute Care (BACPAC) Act (H.R. 1458), NAHC appreciates this opportunity to provide our views. We agree with the Chairman and Ranking Member that we should develop the right reforms in post-acute care (PAC) that can both improve care for today's seniors and help extend the fiscal viability of the program well into the future.

Many studies have found that home health care can prevent expensive hospitalizations and nursing home stays while providing cost effective care in the home setting that people prefer, keeping families together and preserving individual dignity. Our members are participating in the new innovations and demonstration projects with enthusiasm and good ideas, seeking greater efficiency while providing high quality services in the home. We pledge to continue to be good partners in finding solutions.

Significant health care delivery reforms that have the potential to alter how and where patients receive care are currently being tested through the Centers for Medicare and Medicaid Innovation. Overall, many of these reforms shift the focus of care from inpatient services and institutional care to the community setting. Further, these reforms provide a combination of incentives to clinically maintain patients in their own homes and penalties for excessive re-hospitalizations of patients. Importantly, these reforms also focus on individuals with chronic

illnesses, providing support for health care that prevents acute exacerbations of their conditions and avoids both initial and repeat hospitalizations. We believe the demonstration projects that are testing a variety of integrated care models and payment structures will provide valuable guidance on how to reform the post acute care system.

## GUIDING PRINCIPLES FOR POST-ACUTE CARE PAYMENT REFORM

Post-acute care is growing in importance for our nation's Medicare beneficiaries as they age often with multiple chronic illnesses. As the Medicare population evolves, any post-acute care reform proposals should be evaluated under the following guiding principles:

1. Individuals should have access to care in the least restrictive and clinically appropriate care setting.
2. The original right of Medicare beneficiaries to have the freedom to choose any qualified provider should be preserved.
3. Payment and service model reforms should be developed with the participation and input of all stakeholders.
4. Any pre-existing, nonessential regulatory barriers to full success of the reforms should be removed.
5. With the great diversity in the Medicare population, any payment model should rely on a robust risk adjustment that fairly reflects the nature of the population served in the model.
6. Systemic reform should follow the pilot testing of multiple reform model options that are designed to determine the best path forward.

## ENSURING THAT PROPOSALS TO "BUNDLE" POST-ACUTE BENEFIT PAYMENTS FOCUS ON COMMUNITY-BASED CARE OPPORTUNITIES: A MODEL TO CONSIDER

A central goal of any reform of Medicare post-acute care payment models should be to provide the greatest possible degree of support for care in the community rather than in an institution. People prefer care in the community in their own homes.

To achieve that end, we believe it is important that best PAC payment bundling arrangements are managed by post-acute care providers rather than acute care providers. The expertise in post-acute care lies in the post-acute care community. The payment model and care accountability should be structured to reflect that. We are encouraged that CMS is testing a post-acute care bundling program where all provider payments are managed by post-acute care providers, including home health agencies. We believe this will ultimately deter unnecessary re-hospitalizations, thus reducing health care risks and cost. This approach is comparable to the tried and tested Medicare hospice program where payment is bundled to a community-based hospice program where hospitalization is the exception rather than standard practice.

A community-based care model for PAC bundling can operate in a number of ways. Given the evidence regarding the importance of involving home health providers early in the care transitions process, the most effective bundling model integrates community-based care providers such as home health agencies into the hospital discharge planning process upon the

admission of a qualified patient to the hospital. The home health agency would be responsible for a comprehensive evaluation and PAC planning process that is designed to determine whether a patient is medically appropriate and feasible for discharge to the community.

Where the home health agency, in close coordination with the hospital, determines that community based care is not appropriate immediately upon hospital discharge, the responsibility for discharge to a post-acute inpatient setting can be returned to the hospital. At that point, a post-acute inpatient care bundling may be triggered, if available.

With this model, the home health agency is responsible for any community-based care related to the patient's inpatient treatment including home health services, physician services, outpatient rehabilitation services, and any intervening stay in an inpatient rehabilitation facility (IRF), long term care hospital (LTCH), or skilled nursing facility (SNF). Post-acute inpatient stays immediately following hospital discharge are outside of the home health agency responsibility.

Benchmarks could be based on existing measurements of quality and patient outcomes in combination with cost avoidance outcomes that relate to re-hospitalizations and use of emergent care. Under a post-acute community based care bundling approach, providers would receive a case mix related per capita payment that is calculated on the basis of the combination of services in the bundle, adjusted for performance in a positive or negative manner.

One key aspect of making a bundled payment work is ensuring the technological means to share information among providers. Seamless care transitions depend on physicians, hospitals and home health agencies having access to patient information. The home care community has been an integral partner within the Standards and Interoperability (S&I) Community-Led Initiatives, such as the Longitudinal Coordination of Care (LCC) workgroup, to develop standards for interoperable transitions of care and care plans additions to the Consolidated Clinical Document Architecture (CCDA). Our goal is to leverage the support of these important editions to the CCDA to encourage the adoption of electronic health records (EHR) and also to support the interoperable exchange of health information that is the foundation for building new models of care delivery in home care.

We also believe that the use of telehealth should be a high priority in a PAC bundling system as Congress considers evidence-based reform proposals to advance the nation on the fast track toward a highly functioning, technologically enabled, modernized health care delivery system. When deployed in the home as a service of home health care, remote patient monitoring technologies greatly enhance the cost savings potential of PAC. Seniors are able to remain in their homes longer, delaying costly transfers to higher acuity care settings, while being more engaged with their care and having higher levels of care satisfaction. Providers are able to better manage the care of patients with chronic conditions by monitoring changes in health status with increased frequency and employing advanced analytic tools and data trends to improve service delivery, care coordination and reduce unnecessary emergency room visits and hospital admissions.

## BUNDLING DEMONSTRATION PROJECTS

The Patient Protection and Affordable Care Act (PPACA) (H.R.3590; P.L. 111-148) called for launching a post-acute care bundling pilot program by 2013. Among the bundling

options that are being tested is one where the bundled payments for post-acute services would be held by home health agencies. The Medicare Center for Innovation initiated a four-model Bundled Payments for Care Improvement (BPCI) initiative in 2013. Models 2 and 3 included post-acute care services. Model 3 BPCI is focused on post-acute care services provided 30, 60, or 90 days following an inpatient stay. Currently, there are thousands of providers throughout the nation participating in bundling demonstrations. Among the participants are many home health agency-related organizations.

With Model 3 BPCI, there are 60 awardees with 142 providers actively engaged in Phase 2 bundling of PAC payments and services. Another 240 participants with 4,646 providers are in Phase 1 of the demos.

With Model 2 BPCI, there are 20 awardees with 81 providers in Phase 2 bundling of inpatient and PAC services. Another 364 participants with 2,036 providers are in Phase 1.

These demonstration programs offer the promise of increased understanding of what works and what does not. Proceeding otherwise creates avoidable risks for Medicare and vulnerable Medicare beneficiaries.

Congress should monitor the bundling pilot program authorized by PPACA to ensure that we learn all that is possible before instituting systemic reform. Bundling innovations should also be evaluated in terms of any change in administrative burden on beneficiaries and providers. One area of concern with the bundling of home health services stems from the fact that over one-half of home health patients do not come to home care through an inpatient hospital discharge. Instead, many start home health services following a referral from a community physician who is caring for the patient in a community setting.

Any PAC bundling system must be devised in a manner that recognizes that it might result in multiple payment systems for home health — one for post-acute patients and one for patients entering home care from the community. This multiple-track system could result in uneven Medicare coverage for patients with the same care needs. While bundled payments are a promising innovation, it must be carefully monitored to ensure no adverse unintended impact on care access and quality.

## THE BUNDLING AND COORDINATING POST-ACUTE CARE (BACPAC) ACT

The "Bundling and Coordinating Post-Acute Care (BACPAC) Act" (H.R.1458) offers a model that adds to the dialogue on the many options available to reform post acute care payment. In line with NAHC's longstanding position of advancing innovative reforms, we are supportive of the intended goals of BACPAC and appreciate the efforts of its sponsors. We applaud the fact that BACPAC would take advantage of home care innovations and would waive the homebound and face-to-face physician encounter documentation requirements.

We are concerned, however, that implementing nationwide post-acute bundling at this time would be a massive systemic change without the benefit of the knowledge we stand to gain through the thousands of providers engaged in ongoing PAC bundling models. As such, while BACPAC is an example of bundling to be considered, it is a time for learning what it takes to create the most successful reforms rather than for prematurely imposing an untried, systemic

model of payment and service that would affect the care and lives of over 5 million Medicare beneficiaries who use post-acute care annually.

The BACPAC bundling model addresses partially some of the most important issues presented in a bundling design. For example, BACPAC sets out the standards for what Medicare services are included and excluded in the bundle. However, with the exclusion of such items as physician services, BACPAC preempts alternative approaches in an area that is part of the learning expected from the current demonstration projects.

Another concern is that much of the design for PAC bundling is left to CMS and HHS. For example, the risk adjustment that is essential to the success or failure of a bundling model includes some parameters, but at a level of specificity that falls short of insuring that the congressional intention is secured in implementation.

Finally, any bundling reform should be integrated with the recently enacted IMPACT Act (H.R.4994; P.L.113-185) which has a deliberate timeline for developing the uniform assessment tools to enable bundling in the post acute setting. That assessment is a key component to effective care management of Medicare beneficiaries in need of post acute care. It will drive decisionmaking in terms of both care and the care setting.

## CONCLUSION

NAHC wishes to thank the Committee for its leadership in this increasingly important area of Medicare policy. We are open and available to the Committee at any time to continue the dialogue on this vital subject.

PREMIER

**Statement for the Record**

**Submitted by**

**The Premier healthcare alliance**

**House Energy and Commerce Subcommittee on Health**

**"Medicare Post Acute Care Delivery and Options to Improve It"**

**April 16, 2015**

The Premier healthcare alliance appreciates the opportunity to provide a statement for the record of the House Energy and Commerce hearing, titled "*Medicare Post Acute Care Delivery and Options to Improve It.*" Premier, Inc. is a leading healthcare improvement company, uniting an alliance of approximately 3,400 U.S. hospitals and 110,000 other providers to transform healthcare.

Among the more than 110,000 alternative care sites in the Premier alliance are skilled nursing facilities, home health agencies, rehabilitation centers and long-term acute care facilities. Together, Premier's hospitals, post-acute care sites and other providers are seeking better ways to reduce the fragmentation of healthcare and increase coordination of care. Premier operates a number of large-scale collaboratives, including those focused on bundled payment and accountable care organizations (ACOs), in which Premier health systems push for improved quality at a reduced cost.

We applaud the leadership of Chairman Joe Pitts and Ranking Member Gene Green for holding this important hearing. While there are many initiatives our alliance members can undertake on their own to improve the quality, safety and affordability of healthcare, continued government

action is needed to fix perverse payment incentives and foster greater coordination of patient care.

**Aligning incentives across the full continuum of care through bundled payments**

The current fee-for-service (FFS) payment system impedes healthcare providers' attempts to achieve high-quality and cost-effective healthcare. Premier believes that one promising approach that breaks down the existing silos of care aligns providers' incentives and improves patient outcomes and satisfaction is bundled payment.

Because of the goal of coordinating care, bundled payments can include participation by multiple provider types across the continuum of care. We believe it is critical to include the full continuum of care across payment silos to improve patient outcomes and achieve better value. Bundling post-acute care payment systems alone will not achieve the transformations that patients, providers and the government are seeking.

A post-acute care bundled payment model based on hospital-related conditions that does not include the inpatient hospital stay in the bundle is similar to constructing a building without starting with the foundation. For episodes that start with a hospital stay, such as hip/knee joint replacement, the episode should include the hospital stay and a time prior to hospitalization. Including acute inpatient and post-acute care into a single payment bundle provides the most opportunity for market innovation in post-acute care coordination for Medicare beneficiaries. Unlike the existing silo-based fee-for-service arrangements, providers would have strong incentives to work together to provide quality, cost-effective services across the acute and post-acute spectrum of care and to actively manage transitions between sites of service. With a single payment bundle triggered by a hospital stay, preventable hospital readmissions and medically unnecessary use of post-acute services would be discouraged, and quality measures could be employed to ensure that beneficiaries receive the post-acute services needed to promote the best outcome.

By contrast, creating a bundle for post-acute payment that is separate from the acute inpatient stay that triggers the bundle continues the fragmentation of care that does not serve the best

interests of Medicare beneficiaries or the Medicare program. This fragmentation leads to poor care transitions and care coordination among providers, which hurts outcomes of care and patient satisfaction. While a separate bundle would offer post-acute providers new incentives to improve coordination within the bundle, innovation would be stifled by excluding the payment for the hospital stay that is integral to defining the episode of care. For example, a patient plan of care initiated for the post-acute bundle that is separate from the discharging hospital's planning and readmission reduction efforts could result in duplication of effort among providers, confusion for beneficiaries and their families, and might not achieve the most efficient use of Medicare's resources.

There are many examples of the fragmentation and divergence from patient-centeredness that could emerge based on segmenting a bundled payment. Some examples include the exclusion of the admitting physician and care team from the planning and implementation of the post-acute bundle, issues related to communication for the transition of care, and the need for the development of multiple care plans - one for the acute stay, and then one developed by the PAC entity responsible for the bundle for the post-acute timeframe. For an improvement in clinical outcomes to be achieved, there is a need for consistent planning across the continuum of care. Best practices for discharge planning, such as Project RED[1], suggest that a team-based approach with consistent care planning and communication leads to the best outcomes. By not officially including the care team from the hospital in the bundled payment, there is a large possibility for inconsistency between the two care plans.

The Medicare Payment Advisory Commission (MedPAC) identified a number of advantages to bundling payments for combined hospital-post-acute care, including encouraging care coordination between providers, encouraging more efficient resource use across an episode of care, narrowing the wide variation in post-acute care spending and improving quality of services. Specifically, in the June 2013 report to Congress, MedPAC noted that a post-acute care-only bundled payment model may not achieve the levels of care coordination of larger hospital plus post-acute care bundles because providers would have fewer incentives to coordinate care between the hospital and the PAC settings. In addition, the commission noted

[1] https://www.bu.edu/fammed/projectred/newtoolkit/ProjectRED-tool2-how-to-begin.pdf

that post-acute care providers could encourage physicians and discharge planners to refer beneficiaries to post-acute care, which could generate unnecessary care. Commissioners also discussed that improved care coordination could result in better and fewer care transitions between settings, lower risk of readmissions, and less time elapsed between hospital discharge and post-acute care admission.

A combined inpatient plus post-acute care payment bundle builds on incentives already in place in the Medicare hospital payment system. Medicare's inpatient Value-based Purchasing (VBP) program scoring system heavily weights hospital performance on a measure of Medicare spending per beneficiary that includes all expenditures for an episode of care beginning three days prior to a hospital stay and extending through 30 days post-discharge. Because post-acute providers are not affected by the inpatient VBP program, incentives are not aligned and hospitals currently have little or no ability to affect the post-acute expenditures that are a key component of their performance on this measure. Additionally, the substantial penalties in place under Medicare's Hospital Readmission Reduction Program have already led hospitals to develop innovative post-discharge care management programs for Medicare beneficiaries at risk of readmission. A combined payment bundle would encourage more fruitful results from these requirements by aligning post-discharge care coordination activities of hospitals with those of post-acute providers, and providing the tools needed to ensure that care is delivered efficiently throughout an episode of care.

**Advancing bundled payments through a permanent, national program including acute and post-acute care**

We believe it is time to move beyond pilot programs and implement a broad-scale, permanent, voluntary bundled payment program that includes both acute and post-acute care. Whereas a post-acute care bundle that excludes the acute care portion is wholly untested, this type of model has already been tested by the Centers for Medicare & Medicaid Services (CMS) through the Acute Care Episode Demonstration, among other programs, and such arrangements are successfully operating in the private sector. Premier members have participated in these

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programs, as well as the Center for Medicare & Medicaid Innovation's Bundled Payments for Care Improvement (BPCI) initiative that is currently underway.

With the investment of time and resources needed to implement bundled payments, providers can be reluctant to engage in these transformative efforts because of uncertainty about whether such payment systems will ever be deployed widely. The enactment of a national, voluntary bundled payment program would provide certainty to providers by placing a stake in the ground, signaling that Congress and CMS are dedicated to improving quality and safely reducing costs for Medicare beneficiaries through such a mechanism. This will assure providers that bundled payment is not a passing fad, but one they can invest in for the long term. At the same time, making it a voluntary program will give providers time to redesign their care processes and take steps that will allow them to transition to accepting greater payment risk.

With sustained diligence and oversight by Congress to advance models such as bundled payments that create incentives for efficiency and better care coordination, we are confident that we will continue on the path toward higher quality care while bending the cost curve.

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**Statement**

**of the**

**American Hospital Association**

**before the**

**Health Subcommittee**

**of the**

**Committee on Energy and Commerce**

**of the**

**U.S. House of Representatives**

"Hearing to Review Bipartisan Legislation to
Strengthen Post-Acute Care for Medicare Patients"

**April 16, 2015**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to provide input on the Bundling and Coordination Post-Acute Care (BACPAC) Act of 2015. BACPAC would bundle payments for post-acute care services provided during the 90 days following a hospital discharge. The payment amount would be determined based on a new system that would calculate an amount based on the patient's age, overall health and the condition being treated. Under the bill, a variety of entities could serve as a bundled payment convener, including hospitals, post-acute care providers and insurers. For eight years, beginning in fiscal year (FY) 2020, bundled payments for these services would be set at 96 percent of what would have otherwise been paid under Medicare fee-for-service.

There is widespread agreement that new payment and delivery models are needed to improve our health care system to achieve a better patient experience, better population health and lower per-capita costs. Our members are testing many new payment models in both the public and private sectors – there is still much work to be done, with many potential paths and policies available. **As this work is ongoing, the AHA believes now is the time to dedicate resources toward building the knowledge base needed to improve our health care delivery system by testing new models on a small scale and using the lessons learned to develop proposals before considering widespread adoption and implementation.**

Bundling payments is a complex undertaking in which post-acute care plays a critical role. Our members strive to provide the right care in the right setting, but a lack of care coordination in the fee-for-service system produces significant variation in how patients receive post-acute care. Clinically similar patients experience a wide array of post-acute care clinical "pathways." In fact, the AHA has conducted an extensive analysis that shows there are more than 8,800 different patient pathways, with significant variation in the type and total count of unique post-acute visits, in the 60 days following hospital discharge. Even when looking at selected high-frequency conditions, there are still more than 1,000 unique clinical pathways following discharge.

Our analysis and other research also show that the first care setting after discharge from a general acute-care hospital is a major driver of both the clinical pathway the patient will follow and the overall Medicare payment for that episode of care. Thus, bundled payment arrangements present many opportunities to re-tool the types and mix of post-acute care, and materially improve patient care and lower costs. Such efforts may include more standardized hospital discharge practices and post-hospitalization protocols for medical, rehabilitation and other post-acute care services. However, bundled payment arrangements also present many challenges, as providers will face substantial risk if they do not have tools available to understand and select the post-acute and other services that will achieve the best outcome for a given patient.

**The AHA agrees that several key elements of BACPAC are a step in the right direction. However, we also have concerns with the bill, which include its potential to preempt valuable work already undertaken in this area; its reliance on the "Continuity Assessment Record and Evaluation (CARE) Tool" as a patient assessment instrument; and its inappropriate adjustment for readmissions. Our detailed comments are outlined below.**

**BACPAC CONTAINS MANY POSITIVE ELEMENTS**

We support several elements of the BACPAC bill, which would build stakeholder support for the bundled payment model, as well as contribute to successful bundling payment outcomes. For example, we appreciate that this bundling approach would allow post-acute care providers to engage as conveners. Indeed, post-acute care organizations are actively engaged in the Center for Medicare and Medicaid Innovation's Bundled Payments for Care Improvement (BPCI) initiative. And they are interested in continuing to lead and shape the development of payment and other health care reforms. We also support the bill's longer episode window of 90 days, which we believe aligns with a post-acute-only model since many patients receive post-acute care for elongated periods, such as home health (HH) patients treated for one or more 60-day episode, and higher-acuity patients in the long-term care hospital (LTCH), inpatient rehabilitation facility (IRF) and skilled-nursing facility (SNF) settings.

In addition, we strongly support the waiver of post-acute care regulations that could otherwise artificially restrict the provision of the most appropriate patient care, including the LTCH "25% Rule," the IRF "60% Rule," the SNF three-day stay requirement and the HH face-to-face requirement. Further, we appreciate that BACPAC's post-acute regulatory waivers are more comprehensive than those offered to participants in the BPCI program. These regulations do not make sense in a bundled payment scenario and waiving them would give valuable flexibility in

designing new approaches to increase quality, reduce unnecessary costs and craft more streamlined clinical pathways that fit each patient's unique medical needs.

BACPAC COULD PREEMPT ONGOING WORK WITH BUNDLED PAYMENT MODELS

**Overall, the AHA believes it would be most productive to allow the Centers for Medicare & Medicaid Services (CMS) to focus on completing its work on bundled payment under the BPCI initiative, which is well underway, before committing to a particular bundled payment approach for post-acute care.** BACPAC would defer full development of many core bundled payment policies to CMS, including payment rates, a payment process, provider network requirements, a patient assessment process and quality standards. Yet, variations on these policies are being developed and tested in the BPCI initiative at this time. Committing to a specific approach now could preempt BPCI's results and preclude CMS from utilizing the lessons learned to create the best and most effective bundling models possible.

More specifically, the Affordable Care Act (ACA) authorized the testing of multiple innovations such as bundled payment and shared savings approaches – both of which could fundamentally change the role of post-acute care. Under the BPCI initiative, four bundled payment models were rolled out in 2012 and are currently being tested in the marketplace. These demonstrations are intended to inform policymakers about realistic payment, operational and clinical practices on which to base a sound, national bundled payment program. Similar to the BACPAC bill, one of BPCI's models is a post-acute care only approach; 20 groups representing 81 providers are currently actively testing this model.

**In addition, the BACPAC bill needs to be examined in the context of and harmonized with current law.** Specifically, attempting to layer BACPAC's patient assessment, quality measure and payment requirements on top of those established by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which is expected to be the subject of rulemaking in the coming weeks, would be duplicative and premature. Through the IMPACT Act, Congress mandated that CMS develop long-desired infrastructure for consistent patient assessment and quality data for all post-acute settings: LTCHs, IRFs, SNFs and HH agencies. The data collected under IMPACT will enable analysis and comparisons of patient acuity, treatments, cost of care, outcomes and more across the four post-acute settings. Such cross-setting analyses will be insightful for policymakers and providers working on current and future improvements to post-acute care. These new insights will help shape the ongoing re-tooling of bundling, shared savings and other innovations that are in the testing stage.

CONCERNS WITH THE USE OF THE CARE TOOL

**The AHA finds the bill's potential use of the "CARE Tool" as a patient assessment instrument problematic.** While we recognize the value of patient assessment instruments to help ensure clinically appropriate placement into the setting immediately following hospitalization, the CARE Tool has significant weaknesses. First, it is not actually designed to yield a recommendation as to the most clinically appropriate placement post-hospitalization. In addition, it has been widely criticized for its length and for its inability to capture the full spectrum of medical acuity for post-acute care patients – particularly for those with the highest acuity.

CMS itself is aware of the CARE Tool's shortcomings within a bundled payment context – it had been slated for use in the BPCI initiative but was ultimately tabled. At first, providers had requested a shorter, less burdensome version, which resulted in the development of the "B-CARE Tool." However, even the B-CARE Tool was found to be too time-consuming while, at the same time, not offering any "added advantage" toward improving the care of patients, since most organizations already have procedures in place to gather the relevant data. A further critique is that the tool provides only a single point-in-time assessment and does not provide sufficient evidence of rehabilitative trends or changes in functional status within the episode. Ultimately, the B-CARE Tool, which was withdrawn from use in BPCI, may be more useful for providing case-mix adjustments for Medicare episode payments, and less useful as a patient assessment instrument.

Instead, post-hospital placement should be based on patients' clinical needs, and discharge planning tools should incorporate physician and other clinicians' judgment, be administratively feasible, not add to current reporting burdens and help clinicians optimize health during a hospital stay and facilitate restoration of function. Recognizing this, hospitals and health systems have actively sought innovative ways to help ensure that patients are discharged to the most appropriate care setting, with the ultimate goal of improving the overall quality of care for patients and reducing readmissions. Rather than using the unwieldy CARE Tool, many organizations have developed their own patient discharge tools designed to reduce variation in post-hospital placement and avoidable readmissions. To that end, in January, the AHA issued a report highlighting the efforts of five organizations working to improve patient care transitions through the development and implementation of hospital discharge planning tools.

**CONCERNS WITH THE PROPOSED READMISSION POLICY**

Finally, the AHA is concerned that the BACPAC bill's proposed adjustment for readmissions is inappropriate and unnecessary. Specifically, it would reduce the amount of a bundled payment by the aggregate amount paid for any readmissions to acute care hospitals within the 90-day episode covered by the bundle.

We certainly agree that reducing unnecessary readmissions is an important goal. However, the bill fails to recognize that not all readmissions can, or should, be prevented. While some readmissions may be avoided if the patient receives the right care at the right time, others may be unavoidable due to the natural progression of disease, accepted treatment protocol or a patient's preferences. Some readmissions are part of a planned course of treatment. Furthermore, the structure of a bundled payment already creates a strong incentive for providers to reduce readmissions. A basic assumption behind most bundled payment arrangements is that they create a financial incentive to coordinate care across settings, and provide less costly care interventions where appropriate to reduce the need for inpatient hospital services.

In summary, the AHA appreciates the opportunity to share our feedback on the BACPAC bill. Now is the time for testing and learning rather than adoption and implementation. We support the bill's broader objective of improving care and bringing new efficiencies to the

delivery system. We encourage continued discussion and policy work to develop a sound post-acute care only bundle payment model.


Bruce M. Gans, MD
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National Medical Director for Rehabilitation, Select Medical

**House Committee on Energy and Commerce**
**Subcommittee on Health**

***Hearing on "Medicare Post Acute Care Delivery and Options to Improve It"***

**Written Statement**
**Bruce M. Gans, M.D., Chair**
**American Medical Rehabilitation Providers Association**

April 16, 2015

The American Medical Rehabilitation Providers Association (AMRPA) appreciates this opportunity to submit a statement for the House Energy and Commerce Health Subcommittee on "Medicare Post Acute Care Delivery and Options to Improve It." AMRPA is the national trade association representing more than 500 freestanding inpatient rehabilitation hospitals and units (IRH/Us), outpatient rehabilitation service providers, and skilled nursing facilities (SNFs), as well as a number of long-term care hospitals (LTCHs). Like acute care hospitals, federal regulations require IRH/Us to provide hospital-level care and to be staffed around the clock by specialized physicians and nurses who provide intensive rehabilitation care through interdisciplinary teams made up of therapists and other professionals. IRH/Us seek to maximize patients' health, functional skills, and independence so they can return to their homes, work, or an active retirement.

AMRPA encourages the Subcommittee to carefully examine whether H.R. 1458, the Bundling and Coordinating Post-Acute Care (BACPAC) Act, or other proposals that seek to equalize payments among different providers generate Medicare savings and do so without compromising the quality of care delivered to patients. And as part of its examination of these potential reforms, the Committee should assure that any post-acute care changes preserve Medicare beneficiaries' access to the appropriate level and intensity of medical rehabilitation. AMRPA appreciates that in passing the Improving Medicare Post-Acute Care Transformation (IMPACT) Act (P.L. 113-185), Congress recognized the need to collect and standardize data across post-acute care settings to understand the value of care provided in each setting and serve as a foundation for any future post-acute care reforms.

**The Value of Inpatient Medical Rehabilitation**

IRH/Us provide intensive medical management by specialty-trained physicians, extensive rehabilitation nursing care by registered nurses, and rigorous and varied therapy services. Medicare requirements for IRH/Us are stringent and different from those required of other post-acute care providers. For example, to be classified as an IRH/U, the hospital must have medical directors and nurses who specialize in physical medicine and rehabilitation, have 60 percent of admissions come from 13 specific diagnoses, and can only admit patients who can sustain 3 hours of therapy a day and have the potential to meet predetermined goals. IRH/Us treat medically complex patients recovering from strokes, brain injuries,

spinal cord injuries, neurological diseases, major musculoskeletal disorders, and transplantation. However, unlike acute care hospitals, which focus on a patient's diagnosis in developing a care plan, IRH/Us consider an individual's function, other patient characteristics, and environmental factors in determining the appropriate care for that individual.

The Medicare Payment Advisory Commission's (MedPAC's) March 2015 Report to Congress paints a picture of a sector that is constrained. MedPAC notes that the volume of Medicare fee-for-service (FFS) beneficiaries treated in IRH/Us remained relatively stable since 2011, but has declined considerably since 2004. Although the supply of IRH/Us has been declining since 2005, the Commission found that the aggregate supply of IRH/Us declined only slightly between 2012 and 2013 to 1,161 providers with approximately 38,000 beds. In January 2010, CMS adopted new, more restrictive medical necessity coverage criteria, which has further limited the growth of IRH/Us admissions. Unlike other post-acute care providers that have experienced explosive growth, spending on IRH/Us accounts for less than 1.2 percent of total Medicare expenditures and has remained flat.[1]

Dobson DaVanzo & Associates, LLC completed a study in 2014 comparing clinically similar Medicare FFS beneficiaries over a two-year period following discharge from IRH/Us or nursing homes. The study, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge*, found that:

- Patients treated in rehabilitation hospitals or units return home 14 days sooner than patients treated in a nursing home;
- Rehabilitation hospital patients also remain at home 51 days longer than similar patients in nursing homes;
- Inpatient rehabilitation hospital and unit patients had fewer hospital readmissions and emergency room visits than nursing home patients;
- Individuals who receive care in an inpatient rehabilitation hospital or unit live 52 days longer on average than patients in nursing homes; and
- IRH/U patients experienced an 8 percent lower mortality rate during the two-year study period than SNF patients.

This study provides evidence of the differences in care provided by IRH/Us compared to nursing homes. These results confirm the existing understanding of the stark differences between the two settings; moreover, the results are not surprising given that Medicare requirements for IRH/Us are more rigorous than other post-acute care providers. When exploring payment and delivery reforms, policymakers should consider patients' health outcomes over the longer term (*i.e.*, two years) not simply over a 30-day or 90-day timeframe to avert any real harm to Medicare beneficiaries. Because of the implications and evidence for longer term results, the Dobson DaVanzo study should be part of the research that Members of Congress use as they consider Medicare post-acute care reforms.

AMRPA cautions policymakers that there are already too many payment policies and practices as well as proposals restricting access to inpatient rehabilitation services, including the following:

- Arbitrary quotas or categorization systems, such as the 60 percent compliance threshold for IRH/Us, that constrain admission of medically appropriate patients;
- An arbitrary cap on outpatient therapy for Medicare beneficiaries;
- Limitation on the number of days for the rehabilitation hospital benefit by various payers;
- Denials of coverage for inpatient rehabilitation hospital care by managed care companies that are financially motivated to steer patients into a seemingly less expensive setting;

[1] Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy (March 2015).

- Coverage denials on the basis of medical necessity that are made by clinicians who do not have sufficient knowledge, experience, or expertise about rehabilitation to make such determinations;
- Non-coverage of durable medical equipment (DME) including expensive, but necessary, equipment like powered wheelchairs;
- Use of patient screening tools that do not consider the long-term consequences of site of service decisions;
- Policies that allow denial of coverage of rehabilitation services that do not meet "improvement" standards as opposed to a goal of maintenance of function;
- Retroactive coverage denials that presume (without evidence) that care "could have been delivered in a less intensive setting;"
- Policies that make the assumption that care provided in a SNF is equivalent to the care delivered in an IRH/U; and
- Failure to consider compelling evidence from studies that show life-threatening consequences to steering patients into inappropriate clinical settings.

These policies, practices, and proposals harm individuals living with disabling conditions, especially individuals who need rehabilitation services over a longer period of time. A major civil rights movement, resulting in the enactment of the Americans with Disabilities Act (ADA), was prompted because of these and other abuses experienced by individuals with disabling conditions.

In considering post-acute care payment reforms, any new payment system should:

1. Include protections to guard against stinting of care and diversion to less effective care settings and meet the needs of individuals with disabling conditions;
2. Include quality measures that are evidence-based, sensitive and meaningful, and have been proven effective in the long-term (at least two years);
3. Be transparent to individuals with disabling conditions in delineating the clinical differences among care settings so that patients are empowered to make informed decisions about their care;
4. Make quality data accessible to individuals with disabling conditions and caregivers and provide key information about a provider's level of clinical care and patient outcomes;
5. Provide some level of standardization for rehabilitation programs among the various post-acute care settings in order to protect individuals with disabling conditions against receiving inadequate rehabilitation care; and
6. Refrain from relying on "big data" or statistical analytics to guide care decisions because the low incidence of many conditions for individuals with disabling conditions is not large enough to allow for meaningful use of predictive tools.

**An Overview of Bundled Payments**

The primary goal of any payment reforms in the post-acute care sector should be to improve patient access to services, choice, and health outcomes. Any payment reforms should avoid financial incentives that jeopardize patient choice and access or lead to inappropriate underutilization of medically necessary rehabilitation services. The intent of bundled payments is to increase efficiency in care provided to patients through both improving health outcomes and reducing costs. Coordinating care for individuals with disabling conditions holds great promise. However, if payment reforms intended to better coordinate care do not consider the longer-term health outcomes and resource use of patients, policymakers put vulnerable Medicare populations and individuals with disabling conditions at risk.

AMRPA believes that an approach to bundling payment could be developed that has the potential to meet the twin aims of improving quality and reducing cost in the post-acute care sector. Bundling typically

involves payment to one accountable entity for a predefined grouping of items and services, which may be supplied by various providers and settings for an episode of care. Whether bundling acute care services with post-acute care services or bundling multiple forms of post-acute services together, it is critical that any bundled payment program include incentives to provide high quality care in the most appropriate setting to improve patient outcomes.

AMRPA believes that reforms with the greatest chance of long-term success do not use reimbursement to try to override clinical decision-making, but instead seek to align payment changes with efficiencies in the delivery of care. The Continuing Care Hospital (CCH) model, which is described in detail below, has the potential to be another success story, moving from a provider-oriented to a patient-centered payment system and improving care coordination. However, the primary medical diagnosis or procedure code is not a predictor of post-acute care needs or resource use and should not be used as such in any program. After all, it is function and health care needs that are the biggest determinants of resource consumption and readmissions in post-acute care settings.

In the 1990s, the Health Care Financing Administration (HCFA, now CMS) funded several studies to assist in the conceptual development of a bundling demonstration, but decided not to pursue such a concept or demonstration further because of, among other things, serious design and accountability problems. These studies included *Issues in Bundling Hospital and Post-Acute Care* by Robert Kane, University of Minnesota, and *Postacute Care in Health Maintenance Organizations: Implications for Bundling* by at the RAND Corporation. Kane concluded that "any bundling approach is subject to temptations for underuse of post-acute care and will need offsetting accountability," that a demonstration is needed prior to considering the proposal, and that demonstration must include extensive work on how to calculate the rate and enhance accountability. The RAND study raised similar issues and urged that a demonstration be done first. These concerns are also acknowledged in the MedPAC June 2008 discussion of the concept.

AMRPA supports careful consideration of alternative payment models, but not as a façade for cutting costs and shifting spending to other parts of the Medicare program, or Medicaid or other payers, at the expense of patients' full recoveries from serious illness and injuries.

**The Bundling and Coordinating Post-Acute Care (BACPAC) Act**

The BACPAC Act (H.R. 1458), introduced by Representatives David McKinley, Jerry McNerney, and Tom Price, recognizes important limitations in the current payment system, but attempts to superimpose a complex new payment model on a tenuous foundation. Although AMRPA agrees that the health care system should explore ways to transition toward patient-centric, episode-based models of care, doing so should not create financial disincentives for patients to receive medically appropriate inpatient rehabilitation care.

Current Medicare payment policies in the post-acute care sector are defined by "silos" of post-acute services and have substantial room for improvement with regard to efficiency and patient-centricity. AMRPA could only support a well-developed bundling proposal that is built upon an adequate foundation of data integration and based on sound evidence with fully developed quality measures and risk-adjusted payment systems. At this time, a bundled payment system that includes critical beneficiary protections does not exist, and it would likely take several years to develop, adequately test, and validate.

AMRPA hopes to work with policymakers to include sufficient safeguards for patient access and choice in the BACPAC Act. We are unable to support the legislation in its current form. The potential savings to the Medicare program from prematurely implementing a bundling payment system on the current

foundation are dubious and far outweighed by the unjustifiable risk to Medicare beneficiaries. AMRPA applauds the sponsors for making changes to the legislation since it was originally introduced in the 113th Congress. At a minimum, we propose the following important revisions to the most recently introduced version of the BACPAC Act:

- **PAC Physician**: AMRPA supports the BACPAC's designation of a physician as the primary person responsible for delivering post-acute care services. The legislation should include a requirement that this physician have experience in post-acute care/rehabilitation service delivery, including the implementation of post-acute care plans.

- **Holder of the Bundle**: AMRPA opposes the proposal to permit acute care hospitals and insurance companies to serve as the "holder" of the bundled payment for the 90-day bundling period. Regardless of their ability to bear risk, this approach imposes formidable incentives to divert patients to the least costly setting, regardless of patients' specific clinical needs. Regardless of the structure, the bundle holder should be accountable for performance across a series of quality and outcome measures to protect against underservice and stinting on medically necessary care. There should also be a method to measure these outcomes within a short timeframe as opposed to looking at them retrospectively annually.

- **Risk-Bearing Entities**: The holder of the bundle must be able to assume fully the risk of holding this bundled payment while providing services to a beneficiary over a 90-day episode of care. The legislation should require financial solvency and related standards to ensure that bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. These standards should be specifically adapted to the post-acute care setting.

- **Exemption of Certain Vulnerable Patients from First Phase of Bundling**: Bundling is a concept that has not been sufficiently tested and, while AMRPA does not oppose the concept, we strongly believe that adequate safeguards must be included in any legislation to protect vulnerable Medicare beneficiaries. Among these beneficiaries are people with traumatic brain injuries, spinal cord injuries, moderate to severe strokes, multiple-limb trauma, amputations, and severe neuromuscular and musculoskeletal conditions. While these subgroups constitute a minority of Medicare beneficiaries served on an annual basis, they constitute particularly vulnerable subgroups that ought to be exempt from the initial phases of any bundled payment system, until new payment systems can demonstrate sufficient quality outcomes, risk adjustment, adequate payment levels and patient safeguards to ensure quality care. Meanwhile, other subgroups have a clearer care and cost trajectory and may be more readily adaptable to post-acute care bundling such as lower extremity amputations. Several participants in the Bundled Payment Care Improvement (BCPI) initiative are testing bundling such cases. The demonstration projects should be completed, however, before any further steps are taken.

- **Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle**: AMRPA believes that certain devices and related services should be exempt from the bundled payment system. For example, customized devices that are relatively expensive and intended to be used by only one person should be separately billable to Medicare Part B during the 90-day bundled period, as well as prosthetic limbs and orthotic braces, custom mobility devices and Speech Generating Devices ("SGDs"). Under a bundled payment system, there are strong financial incentives to delay or deny access to these devices and related services until the bundle period lapses. Once this

occurs, Medicare Part B would be available to cover the cost of these devices, but this delay has potentially significant negative consequences for patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the post-acute care stay.

- **Inclusion of Quality and Outcome Measures**: Quality measures must be mandated in any post-acute care bundled payment system to assess whether patients have proper access to necessary care. Today this is one of the most critically important methods to determine whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. However, uniform quality and outcome measures that cross the various post-acute care settings do not currently exist – and sometimes identical measures in settings are not appropriate. The existing LTCH CARE instrument for LTCHs, the IRF-PAI for rehabilitation hospitals and units, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies are all appropriate measurement tools for each of these settings. But the reality is they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute episode of care in ameliorating complex medical conditions and functional limitations of this patient population. Therefore, AMRPA recommends that the following measures be incorporated into the post-acute care system:

    - Access and Choice: Measures should include assessment of whether the patient has appropriate access to the right setting of care at the right time and whether the patient is able to exercise meaningful choice;

    - Function: Incorporate and require the use of measures and measurement tools focused on functional outcomes that include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;

    - Individual Performance: Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the "average" patient;

    - Quality of Life: Require the use of quality of life outcomes (measures that assess a return to life roles and activities, return to work if appropriate, reintegration in community living, level of independence, social interaction, etc.);[2] and

    - Patient Satisfaction: Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of outcomes. CMS or MedPAC should be required to contract with a non-profit entity to conduct studies in this area and factor the results into any final post-acute care bundled payment system in the future.[3]

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[2] These extended functional assessment and quality of life measures are consistent with the World Health Organization's International Classification of Functioning, Disability and Health and the measurement tool designed around the WHO-ICF known as the Activity Measure for Post-Acute Care™ ("AM-PAC"™).

[3] "uSPEQ" (pronounced "You Speak") is an example of a patient satisfaction assessment tool that measures the end user's experience with his or her post-acute care experience. The survey can be answered by the patient, family, or caregiver.

- **Grouping of Condition-Related Groups**: The legislation should provide more clarity regarding how the Secretary of HHS must rank and group condition-related groups (CRGs) for purposes of payments.

- **HHS Post-Acute Care Advisory Committee**: The legislation should direct the Secretary to establish an Advisory Committee of post-acute care providers and health professionals to review and provide input to CMS regarding policy and regulations that affect individuals with disabling conditions.

- **Evaluation Process**: Post-acute care reforms must include vigorous evaluation methodologies to stop flawed payment or delivery systems and accelerate adoption of any successful pilots.

- **Avoid Financial Incentives to Divert Patients to Less Intensive Settings**: In order to protect against diversion of patients to less intensive, inappropriate post-acute care settings, we recommend that any PAC bundling legislation include instructions to the Secretary that payment penalties should be established to dissuade post-acute care bundle-holders from underserving patients or stinting on care.

AMRPA reiterates its concurrence with proponents of the IMPACT Act that introducing bundled payments in the absence of a complete quality picture, infrastructure to seamlessly coordinate services, and contemporaneous data that transcends individual sites of care would be premature.

**AMRPA's Principles for Post-Acute Care Reform**

As the Committee considers bundled payments and other post-acute care reforms, AMRPA developed a set of principles for reform that will help ensure that a reformed payment and delivery system is feasible for providers and beneficial for patients. Specifically, we urge Congress to be guided by the following principles in any reforms to the post-acute care sector:

- While reforming post-acute care, Congress should take steps to reduce the need for post-acute care in the first instance. As a nation, we have a vast amount of knowledge in treating the predominant reasons that patients need post-acute care, including stroke, traumatic brain injury, spinal cord injury, congestive heart failure, chronic obstructive pulmonary disease, and serious wounds. At the same time, we know of ways to prevent them or mitigate their effects. Congress should establish policies that prevent the need for acute and post-acute care as a fundamental step to reducing costs and improving outcomes.

- Qualified clinicians should determine patient care—both with respect to the type and site of care. Clinicians should be empowered to make post-acute care utilization decisions with reasonable criteria that are evidence- and consensus-based. Periodic audits could be utilized to hold physicians accountable to exercising that authority.

- Post-acute care reform should include an accurate definition of post-acute care. The current definition excludes outpatient services and is being driven by how Medicare Parts A and B are defined, not by how care is actually delivered. Post-acute care reform and reinvention will only be ultimately successful by eliminating this arbitrary divide.

- A reformed system should ensure electronic interoperability between and among different providers of care. Post-acute care providers are at the crossroads of information flowing out of the acute care hospitals, yet post-acute care providers were not included in recent health information technology (HIT) incentive programs. The absence of such funding for post-acute care providers has arguably made information sharing worse than before the incentives were provided. Post-acute care providers should be included in HIT incentives to enhance patient care safety and efficiency, and reduce costs.

- A reformed system should create a mechanism to promote frank and open discussion between acute care hospitals and post-acute care providers to identify and rectify adverse health outcomes that occur because of care transitions.

- The current post-acute care system, including provider fee schedules and coverage criteria, is long-standing. Therefore, any changes to this system will require extensive provider, professional, and patient outreach and education. As a result, implementation of a reformed system should include a sufficient transition period and resources for such education. All stakeholders, including health care professionals and patients, should be consulted in the development of any new Medicare payment systems.

- A reformed system should include a quality measurement and reporting system for post-acute care providers that should be based on the principles of:
    - Avoiding adverse events;
    - Achieving positive health outcomes;
    - Achieving positive functional gains;
    - Providing a positive patient experience;
    - Achieving durable health and functional gains; and
    - Demonstrating efficient and cost effective use of resources.

- Payments must reflect the true cost of care and resources utilized based on the patient's conditions. Systems that allow for a fixed number of visits or an average cost limit disproportionally penalize patients with complex disabilities such as spinal cord injuries, brain injuries, and some neurological conditions that require extended rehabilitation.

- Provider administrative burden should be minimized whenever possible. Current regulations that inhibit the use of the most cost effective setting—such as the three-hour rule for IRH/Us and the "25 Percent Rule" for LTCHs—should be eliminated and replaced with incentives to use post-acute care settings prudently.

- The payment eligibility criteria for post-acute care providers should be reformed based on structure, process, and outcomes for each setting, and these criteria should not be confused with defining appropriateness for a specific patient.

**The Continuing Care Hospital Model**

The Continuing Care Hospital (CCH) Pilot Test was enacted in Section 3023 of the Patient Protection and Affordable Care Act of 2010 (ACA), P.L. 111-148, but to date the legislative directive has not been implemented by the Center for Medicare and Medicaid Innovation (CMMI).

AMRPA strongly supported its inclusion in the health care reform legislation. The model is a delivery system reform, not just a payment reform. The CCH concept provides an opportunity to develop a patient-centered care model in which the "silos" established by the variety of Medicare payment systems based on care setting are eliminated. Care under the CCH model is delivered based on need rather than setting, and there is an opportunity to realize cost savings due to efficiencies the CCH model would allow. Payment may also be more reflective of actual cost and resource use and not include the multiple costs associated with meeting the requirements of the current payment systems and transfers among care settings as is currently required.

The CCH represents both a new approach to the delivery of post-acute care and financing reform for the medical rehabilitation and complex medical services delivered by today's IRH/Us, hospital-based skilled nursing facilities (HSNFs) and LTCHs. The model would also provide or coordinate home health and outpatient rehabilitation services for patients who need them after discharge. The CCH model would organize care around the patient instead of the provider by consolidating all three levels of inpatient post-acute care into a single enterprise with a single payment system and single method for measuring quality. The CCH could be either real (all care levels in a common building) or virtual (all levels operated as a single entity, but in two or more physically distinct locations). The CCH is intended to enhance the quality of care patients experience by eliminating the physical and invented boundaries of the current hospital-based post-acute care system. It would result in reduced administrative costs to deliver complex medical and rehabilitation post-acute care, improve the cost-effectiveness of post-acute services, and enhance the quality of care received by patients.

The medical rehabilitation field was developed in the first third of the 20th Century by physicians who believed that there was more to health care than simply diagnosing and medically treating patients with serious permanent impairments. Over the years, physician-directed, hospital-based multidisciplinary teams devoted to the principles of rehabilitation evolved into the field of medical rehabilitation and, as we know it today, the IRH/U. The LTCH field evolved from treating TB and other chronic, medically complex diseases during a similar period. HSNFs also expanded starting with the onset of the DRGs in 1982. The post-acute sector grew with the advent of the inpatient PPS in 1983. With this growth has come confusion about how best to distinguish among the various post-acute facilities and the services they provide.

In 2015, there are about 1,172 IRH/Us organized specifically to provide medical rehabilitation. In addition, MedPAC reports that in 2013 approximately 15,000 SNFs and 408 LTCHs existed to provide medically complex care and some level of medical rehabilitation services to patients. Currently, each of these entities must meet specific conditions of participation, and, in some cases, specific additional criteria, under the Medicare program in order to be reimbursed. The plethora of coverage criteria and definitional standards regarding either the types of patients or processes of care in each of these post-acute care venues has raised concerns in policy circles that there are few objective standards or criteria by which to assign individual patients to specific settings. These factors point to a need to improve the post-acute care delivery system by focusing on patient-centered care. AMRPA proposed the creation of a Continuing Care Hospital to strengthen the delivery system with a focus on patients' clinical needs.

Payment would be determined by the patient's clinical and functional characteristics and the program resources needed to provide that care. Pilot test participants would be allowed to care for certain types of patients if they demonstrate the ability to provide care, as defined by law and regulation, meet specific patient care and patient safety standards, and demonstrate certain outcomes.

Congress should direct CMMI to promptly implement the CCH pilot, as required by statute. Defining the episode of care as a CCH stay plus the 30 days following discharge allows CMS to begin testing a viable post-acute care bundled payment model before having to report to Congress on prospective payment and other post-acute care payment reforms. The CCH pilot requires the use of performance and outcome measures consistent with the IMPACT Act. Although CMMI does not require additional legislation to launch the CCH pilot, which it is already statutorily mandated to do, Congress should ensure that implementation occurs swiftly as an important step in evaluating viable post-acute care payment reforms.

**Conclusion**

AMRPA shares legislators' and policymakers' interest in addressing variation in spending, quality and margins across different sites of service and supports careful consideration of new payment models. We remain concerned that prematurely implementing a bundled payment system presents risks to Medicare beneficiaries that outweigh the potential for Medicare program savings. Bundled payments must not act as a façade for reducing costs and shifting spending to other parts of the Medicare program at the expense of patients' full recoveries from serious illness and injuries. Medicare policies must ensure that individuals with disabilities, serious injuries, life-threatening illness, and other beneficiaries continue to have access to medically necessary inpatient rehabilitation care. Although AMRPA cannot support the BACPAC Act in its current iteration, we look forward to working with the House Energy and Commerce Health Subcommittee in thoroughly vetting proposals that would establish bundled payments for IRH/Us. We thank you once again for the opportunity to provide testimony to the Committee.

NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
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STATEMENT
OF THE
NATIONAL ASSOCIATION OF LONG TERM HOSPITALS

UNITEDS STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

APRIL 16, 2015

Dear Chairman Pitts and Ranking Member Green:

The National Association of Long Term Hospitals (NALTH) would like to thank you for the opportunity to submit a statement for your hearing on "Medicare Post Acute Care Delivery and Options to Improve It." NALTH is the only hospital trade association in the nation that is devoted exclusively to the needs of patients who require services provided by long term care hospitals (LTCHs). NALTH is committed to research, education and public policy development that further the interests of the very ill and often debilitated patient populations that receive services in LTCHs throughout the nation.

We understand and support efforts made in pursuit of improving the quality and efficiency of post-acute care. However, we also recognize that changes that are implemented too quickly and without careful review and testing may have unintended consequences for Medicare beneficiaries, particularly for the most severely ill patients. We believe that the patient populations of LTCHs are particularly vulnerable to unintended consequences from implementation of bundled payment approaches that do not accurately reflect and account for

the high acuity of these patients. Patients treated in LTCHs often possess multiple comorbidities and require specialized care. Because other settings often lack the capacity to provide the care these patients need, our members fill a critical role in the post-acute care landscape.

From this perspective, we would like to share our thoughts relating to the Bundling and Coordinating Post Acute Care ("BACPAC") Act, which can be summarized as follows.

- A systematic approach is needed to developing and testing a post-acute care (PAC) bundled payment approach before implementation to avoid unintended consequences on Medicare beneficiaries, particularly the chronically and critically ill patients cared for in LTCHs.
- Passage of bundled payment legislation before the results and lessons learned from the Medicare bundled payment demonstrations are realized is premature.
- The IMPACT Act provides the foundation for implementing post-acute payment reform. Passage of the BACPAC Act could short-circuit these efforts.

A Systematic Approach is Needed to Allow for Sufficient Quality Measurement Development, Data Collection, and Testing of Bundled Payment

To implement the BACPAC Act or any national bundled payment policy, a number of critical steps would need to be completed. NALTH believes the Centers for Medicare & Medicaid Services (CMS) would need to:

- Implement a new patient assessment instrument,
- Develop a patient classification system (e.g., condition-related group (CRG)),

- Define an episode of care to be covered by the bundled payment
- Determine accurate payment rates for post-acute care (PAC) episodes of care,
- Test the bundled payment model approach to ensure it works as intended, and
- Implement a monitoring system to identify stinting or other unintended consequences.

Episode reimbursement levels cannot be determined until resource utilization data for specific episode types (e.g., CRGs) become available. Data on specific CRGs will not be available until the patient assessment instrument used to produce these groupings is selected, developed, and implemented. Thus, each of these complex steps in the process must be completed consecutively rather than simultaneously.

Any large-scale reform effort holds the potential for severe unintended consequences. A hasty implementation schedule unnecessarily exacerbates these risks, and in this case, could result in unnecessary suffering and premature death for those most frail and ill Medicare beneficiaries. We note that the Center for Medicare and Medicaid Innovation at CMS is testing post-acute care bundled payment demonstrations in the Bundled Payments for Care Improvement (BPCI) initiative. Our hope is that some of the issues described in these comments can be worked out through the demonstration process. However, the passage of bundled payment legislation before the results and lessons learned from the BPCI are realized is premature.

The IMPACT Act Provides the Foundation for Implementing Post-Acute Payment Reform

Congress recognized the need for a measured approach to post-acute care payment reform in the IMPACT Act of 2014. The IMPACT Act establishes an approach to develop and implement standardized patient assessment data for PAC providers (HHAs, IRFs, SNFs, and

LTCHs). The data are intended to facilitate comparisons of patients, quality of care, and outcomes across PAC settings, improve PAC discharge planning, and inform the development of PAC payment reforms. In addition, the Medicare Payment Advisory Commission (MedPAC) and the Secretary of Department of Health and Human Services (DHHS) are required to submit reports to Congress on a prototype PAC payment system and provide recommendations for reforming PAC payments. The passage of the BACPAC Act would short-circuit these efforts.

The approach to PAC payment reform offered in the BACPAC Act is one of a number of alternatives that policy makers could consider. It should be considered along with other approaches by MedPAC and DHHS in their assessments. Moreover, we believe that CMS should have an opportunity to test the approach presented in BACPAC either through the BPCI initiative or some other demonstration to assess its impact on quality and Medicare spending. The results and lessons learned from the current BPCI initiative and other demonstrations could then be used to help inform a PAC payment reform.

More Experience is Needed before Adopting National PAC Bundling

There are many issues to be worked out before a national PAC bundling approach can be unveiled. For example, under the Medicare benefit package the accrual of Medicare benefit days and related beneficiary co-insurance and deductible obligations are closely aligned to traditional fee for service payment systems and the type of provider (e.g., hospital or SNF) in which a beneficiary receives covered services. Bundled payments may affect beneficiary co-insurance and deductible obligations, patient spend-downs as well as Medigap, Medicaid and other secondary payer obligations.

In addition, direct quality monitoring efforts must be developed and used to identify and

correct stinting behavior under bundled payment. The BACPAC Act includes a section on "quality assurance" that requires the PAC network agreement to have a written plan to guarantee high quality care. We strongly support such efforts, and encourage further demonstrations of how such efforts can ensure patients receive necessary treatment. We believe further clarification is needed in this area and specific requirements need to be specified with respect to the monitoring of quality and outcomes.

We conclude by noting that Congress recently enacted legislation that will significantly alter Medicare payments for inpatient services in LTCHs, effective for discharges in cost reporting periods beginning on or after October 1, 2015. The legislation limits full LTCH Prospective Payments to those cases deemed appropriate for LTCH care. Given these changes and the types of patients LTCHs treat, NALTH believes that it is important to proceed cautiously in bundling payments for the most highly medically complex Medicare beneficiaries.

Thank you again for the opportunity to provide a statement. While we commend the work that has been invested in developing the BACPAC Act, we believe additional data and research are needed before such reforms can be implemented in a way that benefits beneficiaries.

Sincerely,

Cherri Burzynski, MSN, RN, NE-BC
President
National Association of Long Term Hospitals


Statement

Of

The National Association of Chain Drug Stores

For

U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

Hearing on:

"Medicare Post-Acute Care Delivery
and Options to Improve It"

April 16, 2015
10:15 a.m.
2322 Rayburn House Office Building

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**Introduction**

The National Association of Chain Drug Stores (NACDS) thanks Chairman Pitts, Ranking Member Green, and the members of the Subcommittee on Health for the opportunity to submit the following statement for the record regarding Medicare post-acute care delivery and options to improve it. NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other healthcare providers to improve the quality and affordability of healthcare services.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS' 115 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 850 supplier partners and nearly 60 international members representing 22 countries. For more information, visit www.NACDS.org.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Through personal interactions with patients, face-to-face consultations, and convenient access to preventive care services,

local pharmacists are helping to shape the healthcare delivery system of tomorrow—in partnership with doctors, nurses and others.

Hospital readmissions are costly and frequently occur soon after discharge. Estimates of the total cost of readmissions range from $15 billion to $25 billion per year.[1] A significant proportion of hospital readmissions are caused by medication-related adverse events. It has been estimated that hospital admissions related to medication adherence costs around $100 billion per year.[2] As a member of the healthcare team, pharmacists are a valuable asset for beneficiaries leaving the hospital or other acute care facility, and through medication adherence-improving activities such as medication therapy management (MTM), can help improve care and reduce healthcare costs.

**The Benefits of Pharmacist-Provided MTM**

In recent years, pharmacists have played an increasingly important role in the delivery of cost-saving, highly efficient healthcare services. Notably, policymakers have begun to recognize that pharmacist-provided MTM improves medication adherence, which lowers overall healthcare costs. For example, a 2013 CMS report found that Part D MTM programs consistently and substantially improved medication adherence and quality of prescribing for evidence-based medications for beneficiaries with congestive heart failure, COPD, and diabetes. In 2014, a Medicare Payment Advisory Committee (MedPAC) study found significant medical side savings in adherent populations compared to the non-adherent population. In addition, a study conducted by Avalere in 2013 concluded that patients who

[1] NEHI, Improving Medication Adherence and Reducing Readmissions, October 2012

are adherent to their medications have more favorable health outcomes such as reduced mortality and use fewer healthcare services. Such patients are thus cheaper to treat overall, relative to non-adherent patients.

How and where MTM services are provided also impact its effectiveness. A study published in the January 2012 edition of *Health Affairs* found that a pharmacy-based intervention program increased adherence for patients with diabetes and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail-order pharmacist.

Pharmacists are engaged with other professionals and participating in models of care based on quality of services and outcomes, such as accountable care organizations (ACOs) and medical homes. Pharmacists now commonly provide immunizations and MTM services and are developing new and innovative approaches through medication synchronization programs, identifying and treating medication adherence issues, and working to be able to provide simple medical testing services.

**Pharmacists as Providers**

In addition to helping reduce post-acute care issues related to medication non-adherence, retail community pharmacists can provide high quality, cost efficient care and services. However, the lack of pharmacist recognition as a provider by third party payors including Medicare and Medicaid has limited the number and types of services pharmacists can provide, even though fully qualified to do so.

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[2] *Id.*

Retail pharmacies are often the most readily accessible healthcare provider. Nearly all Americans (89%) live within five miles of a community retail pharmacy. Recognition of pharmacists as providers under Medicare Part B would help to provide valuable and convenient pharmacist services to millions of Americans, and most importantly, those who are already medically underserved.

The national physician shortage coupled with the continued expansion of health insurance coverage in 2015 will have serious implications for the nation's healthcare system. Access, quality, cost, and efficiency in healthcare are all critical factors – especially to the medically underserved. Without ensuring access to requisite healthcare services for this vulnerable population, it will be exceedingly difficult for the nation to achieve the aims of healthcare reform. For this reason, we support H.R. 592, the "Pharmacy and Medically Underserved Areas Enhancement Act," which would allow Medicare Part B to utilize pharmacists to their full capability by providing those underserved beneficiaries with services not currently reaching them (subject to state scope of practice laws).

The medically-underserved population includes seniors with cultural or linguistic access barriers, residents of public housing, persons with HIV/AIDS, as well as rural populations and many others. Significant consideration should be given to innovative initiatives within the medically underserved population to enhance healthcare capacity and strengthen community partnerships to offset provider shortages and the surge in individuals with healthcare coverage. It is especially important that underserved beneficiaries transitioning from an acute care facility have continued access to a provider for follow up and to ask questions; oftentimes this is the community pharmacist. NACDS urges the adoption of

policies and legislation that increase access to much-needed services for underserved Americans, such as H.R. 592. This important legislation would lead not only to reduced overall healthcare costs, but also to increased access to healthcare services and improved healthcare quality for underserved patients, including those in transitions of care.

**Conclusion**

NACDS thanks the subcommittee for consideration of our comments. We look forward to working with policymakers and stakeholders on these important issues.

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